

MEDICARE REFORM: MODERNIZING MEDICARE AND MERGING PARTS A AND B

HEARING
BEFORE THE
SUBCOMMITTEE ON HEALTH
OF THE
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COMMERCE
HOUSE OF REPRESENTATIVES
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MEDICARE REFORM: MODERNIZING MEDICARE AND MERGING PARTS A AND B

THURSDAY, JUNE 14, 2001

HOUSE OF REPRESENTATIVES,
COMMITTEE ON ENERGY AND COMMERCE,
SUBCOMMITTEE ON HEALTH,
Washington, DC.

The subcommittee met, pursuant to notice, at 10:04 a.m., in room 2123, Rayburn House Office Building, Hon. Michael Bilirakis (chairman) presiding.

Members present: Representatives Bilirakis, Greenwood, Deal, Ganske, Wilson, Bryant, Ehrlich, Pitts, Tauzin (ex officio), Brown, Waxman, Strickland, Barrett, Capps, Pallone, Eshoo, Stupak, Wynn, and Green.

Staff present: Patrick Morrissey, majority counsel; Erin Kuhls, majority counsel; Kristi Gillis, legislative clerk; Bridgett Taylor, minority professional staff, Amy Droskoski, minority professional staff; and Karen Folk, minority professional staff.

Mr. BILIRAKIS. Good morning. I call this meeting to order. Our hearings this year have focused on ways to modernize the Medicare program and to provide an updated benefits package, including a prescription drug benefit. Today this subcommittee will examine Medicare's structure and organization with the goal of improving the financial health of the program and securing the efficient management and delivery of high quality services to its beneficiaries. Structural reform of Medicare is central to the broader goal of protecting and strengthening the Medicare program for the future.

Many experts agree that if Medicare were being designed today, the two-part system that drives its payment policies would not be adopted. At the same time proposals to combine A and B have significant policy implications, particularly for beneficiaries, and we must proceed with caution in considering alternative approaches. Private health insurance formerly organized with separate policies for hospital and physicians services has also moved to a more comprehensive structure. As services once provided only in hospitals are provided routinely on an outpatient basis in physicians' offices and beneficiaries' homes, a reexamination of Medicare's design is warranted. Today we will assess the implications of redesigning Medicare and merging parts A and B of the program.

I am pleased to welcome our panel of expert witnesses. Thank you all for joining us here today. Our first witness is Dr. Bill Scanlon with the General Accounting Office. Recognized for his Medicare expertise, Dr. Scanlon will report on the benefits and technical challenges of merging parts A and B of the program. I would also

like to welcome Dr. Don Young, interim president of the Health Insurance Association of America. Mr. Young's testimony about the structure and organization of health insurance in the private sector will be a valuable contribution to our discussion today.

Our third witness, Mr. Dan Schulder, the legislative director for the alliance of retired Americans, will be able to best explain how structural reform of the Medicare program will affect those the program serves—its beneficiaries.

And finally, Ms. Marilyn Moon, Senior Fellow from the Urban Institute, and Ms. Kathy Means, Senior Public Policy Advisor for Patton Boggs and former Senior Health Advisor to Senator Roth and the Senate Finance Committee round out our panel of respected experts.

Having enjoyed the opportunity to work closely with you in your previous capacity, Kathy, I am delighted to welcome you before the subcommittee today. I am committed to protecting the long-term solvency of the Medicare program and look forward to a productive hearing today which can shed light on some of the fundamental issues in this debate. The financial viability of this critical program, the cost-sharing liability of Medicare beneficiaries and the management and delivery of high quality services for beneficiaries are three of key issues that we will have a chance to explore.

This subcommittee has a strong record of working on a bipartisan basis. We must continue to work together to find bipartisan solutions. This hearing is designed to bring us closer to accomplishing that goal as we evaluate the challenging issues inherent in any Medicare reform proposal.

And in closing, I want to again thank our witnesses for their time and effort and joining us to share their views on the important issue of Medicare reform.

And now I am pleased to recognize the ranking member, Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. I commend and fully support your decision to hold this hearing. The Commerce Committee as a whole, and our subcommittee in particular, has a strong history of successfully addressing important, albeit politically volatile issues and doing so on a bipartisan basis. We do not always agree on the merits of different proposals. In fact, we often express very strong and polar opposite opinions on the merits of different proposals, but we are unified in our desire to give all credible Medicare options a fair hearing.

I want to thank Marilyn Moon and Dr. Young and the other witnesses for joining us this morning. We were fortunate to have a distinguished panel to help us look at the implications of merging Medicare part A and B. It is a particularly complex issue. Not only does this proposal raise many issues, it raises many kinds of issues, policy issues, political issues, even jurisdictional issues. And overwhelming all of these issues is this one, we have not yet addressed the No. 1 issue in Medicare that is the Medicare benefits package lacks coverage of prescription drugs. How can we possibly justify diverting our attention toward changing the financing structure toward Medicare when we have not addressed the most pressing concern that we hear every day from our Medicare constituents?

Merging A and B would not, in and of itself, take us closer to prescription drug coverage, but it would certainly require time and resources that could otherwise be devoted to establishing Medicare prescription drug coverage. Again, it is important to look at the full range of proposals that are currently under consideration by this Congress and the administration, but when it comes to taking action, we should put our priorities in order and tackle prescription drugs first.

But this hearing is about merging A and B. And I want to get back to those issues. The impact of Medicare beneficiaries does not depend explicitly on whether we merge parts A and B. It depends on the objectives we are trying to fulfill by merging the two programs. If the objective is to create efficiencies in the administration of Medicare, that is a pretty tall order. Medicare fee for service spends less than 2 percent of its budget on administration.

Medicare+Choice spends as much as 30 percent of its budget on administration. If the objective is to rationalize Medicare cost sharing, that is a laudable goal, but tricky one to accomplish. Simply merging the two deductibles could reduce hospital costs for a few beneficiaries while increasing physician and other costs for virtually every beneficiary. A net increase in beneficiary liability probably translates in a net increase in Medigap premiums.

It is also important to recognize we don't need to merge parts A and B to modify the cost-sharing requirements associated with Medicare. If the objective is to control Medicare spending by capping the general revenues going into the program, hiding behind a mechanical change and finance of accomplishing that goal does not make the goal more palatable. Unless the plan is to increase payroll taxes, is to compensate for general revenues capping general revenues means one of two things: either shifting more costs onto beneficiaries or starving the Medicare program. Neither option, at least to me, is acceptable.

As I mentioned previously you must consider the cost of implementing this change and given the scarce budget dollars available, in large part because of the tax cut that Congress passed, we must consider how merging parts A and B stacks up against other proposed Medicare modernization priorities like adding prescription drug coverage, like bolstering preventive benefits like giving Medicare the tools and resources it needs to improve internal and contractor performance.

Finally, we should consider the political implications. I don't mean the potential fallout with Medicare beneficiaries or providers, because the only political fallout that should be of concern to this subcommittee is that which reflects harm to the beneficiary or unfair treatment of providers or the misuse of taxpayers dollars.

What I mean by political implications is this: The current administration has made absolutely no secret of the fact that it favors restructuring Medicare into an insurance voucher program, meaning the Federal Government would help pay for private health insurance rather than helping to pay for private health care. Many Democrats believe that privatization is basically a cop-out. It would give Congress and the administration cover to shirk their responsibility for access and for quality. It would give Congress and the administration a mechanism by which to shift more and more the fi-

nancial burden for Medicare onto the shoulders of retirees and retirees' families. And ultimately, it would give Congress and the administration an out.

It is far easier to abandon a program when it is firmly ensconced in the private insurance market than when it is still a federally administered program. If making Medicare fee for service financing system looked more like Medicare+Choice financing system would somehow help the administration or Chairman Thomas or any other proponent of privatization convinced Congress to make the traditional Medicare Program Act more like the Medicare+Choice program, we must be sure to make that possibility transparent to every beneficiary, and we must also carefully evaluate whether we are willing to be coaxed down the path of privatization.

Mr. Chairman, if it is not clear from my comments, I admit to a bias in regards to merging A and B. That is due in part on the President's budget proposal which merged parts A and B for purposes that I consider to be detrimental, in its part due to the fact that I was around for the BBA debate in 1995 and participated then in the fight against merging parts A and B. At that time, merging the two programs, what that meant was clearly an attempt to starve the Medicare program and end the Medicare entitlement, thinking back to the comments of Speaker Gingrich and then-Senator Dole about privatizing Medicare.

That said, I don't doubt the chairman's goal is to determining whether merged financing can be accomplished in a way that actually does improve the Medicare program. I share the chairman's goals in that way and will consider the testimony of our witnesses from that perspective. Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman and I would suggest that the gentleman that I have always considered hearings to be informational. This is why we hold hearings so we can learn. If we have already predecided our position on a particular issue, I don't see the sense in holding a congressional hearing. This is the reason why we are having a hearing because I too want to learn about this particular subject. The chairman would yield to the chairman of the full committee, Mr. Tauzin, who honors us with his presence.

Chairman TAUZIN. Thank you, Mr. Chairman. I am honored to be here. I thank you for having this hearing particularly because it focuses on a question that the committee often faces, and that is whether structures that were designed in a different day and age in our Nation's history still make good sense for today's economy and environment and the method by which we deal with social issues. We often come to this point. We come to it in telecommunications. We are coming to it in energy, and we are certainly coming to it in health care.

It is important, I think in an informational hearing, to look at the history of how we got where we are and whether or not it has relevance in today's world. And we should note that it was 36 years ago, a very historic moment that President Johnson signed the Medicare legislation into law. If we go back and look at those debates, we find there was significant controversy going on into that decisionmaking process. There are those who argue that Medicare should be limited to covering only hospital inpatient stays. In those days, that was the most significant and costly form of coverage.

Others were trying to make sure that other physicians and other outpatient services would be covered in the package.

Some argued that health care covered in the package should be paid for strictly through a dedicated payroll tax, and others wanted, obviously, a combination of general revenues and payroll taxes. Some wanted the system to be automatically an entitlement, and others wanted it to be made voluntarily. You know the cuts that were made, a lot of compromises. And in 1965, the compromises that were made basically reflected the structure of hospital care and coverage of that age. In that day and age, private insurance very often separated hospital insurance and physician insurance. And that concept was adopted into the compromises and hospital insurance called part A and physician insurance called part B were separated in method of funding to reflect, again, the differences of opinion, whether it would be payroll taxes or voluntary contributions that structured each program.

But as we sit here today, Mr. Chairman, and I think Mr. Brown has articulated it well in his closing comments, we ought to consider whether those decisions make sense today. Whether having a part A and a part B make sense in today's health care coverage. For example, private insurance today usually does not separate inpatient hospital coverage from physician services. Beneficiaries today usually do not have a separate deductible for the purpose of hospital inpatient and physician services in the private sector but we have them in Medicare A and B. And significantly, prescription drug coverage is no longer considered a luxury. I mean, it is an integral part today of a patient's treatment regimen. All of us know that.

All of us, most of us, are on some form of medication. Medicare was still operating, in essence, in a 1960's model, and the question is does it work for the 21st century? Well, there are a number of oddities in the A-B structure that we ought to focus on. One is that part A deductible is \$792, and this deductible increases every year. And by contrast, part B is \$100 that has not been indexed for inflation for 10 years. Private insurance companies have a unified deductible. Should Medicare have a unified deductible, and what should it be? Tough question.

The part A trust fund is expected to go insolvent in the year 2029. Part B does not go insolvent because an ever increasing amount of general revenues flows into the program. Is there anything more prudent to measure the long-term viability of Medicare part A and B together particularly when part B is growing as it is. Because of the distinctions between part A and B, it is extremely difficult for the program to implement comprehensive disease and case management strategies that focus on total services provided to a beneficiary. Shouldn't we have a system, for example, that effectively tracks when a patient leaves an inpatient hospital setting and moves to an outpatient setting? You think you would if you wanted to manage long-term treatment.

Claims processing has to be performed by fiscal intermediaries for part A and it is performed by carriers for part B. Shouldn't A and B processing functions be combined and performed by a single contractor? By eliminating the distinction between fiscal intermediaries and characters, we probably could be able to reduce the

number of contractors from the 50 or so today to 10. And that might be a good reform. Partially because of the separate program parts and the widely disparate cost-sharing structures, Medicare currently does not place a cap on beneficiary liability. And the question we should ask, Mr. Brown and all of us should ask who love our seniors and love those of our family who are covered by Medicare, shouldn't we have a system reform that Medicare beneficiaries are better protected from liability for the prolonged illnesses that unfortunately plague us now? These are some of the questions. Here is the most important one we should ask ourselves. If we were building Medicare today from scratch instead of having to deal with the decisions made in 1965, would we build this system the way it is currently constructed? You know that. And not a person in this room, I think, would build it the way it is currently constructed.

I think we make better decisions based upon the way in which we provide health care services and coverage for seniors today. If that is true, then this committee owes it to every single beneficiary and patient care provider under this system to reform it. And this is a hearing that is going to lead us hopefully to some of those answers, and I thank you for having it, Mr. Chairman.

[The prepared statement of Hon. W.J. "Billy" Tauzin follows:]

PREPARED STATEMENT OF HON. W.J. "BILLY" TAUZIN, CHAIRMAN, COMMITTEE ON
ENERGY AND COMMERCE

Thank you, Mr. Chairman for holding this important hearing. Our Committee has spent a great deal of time examining Medicare structural reform in recent months, so I am pleased that we are focusing attention on this critical issue of whether we should merge Parts A and B of the Medicare Program.

Thirty six years ago—in a historic moment—President Johnson signed Medicare legislation into law. For the first time in our nation's history, we guaranteed seniors' access to basic health insurance.

During the years leading up to the passage of Medicare, many ideas were debated about how this new Program should be designed. Some argued that Medicare be limited to covering hospital inpatient stays, since that was the most costly type of coverage. Others insisted that physician and other outpatient services be included in Medicare's basic benefit package. Some argued that all of the health services covered under Medicare be paid for through a dedicated payroll tax; still others, demanded that the system be funded through a combination of general revenues and beneficiary premiums. Some demanded that the Program be an automatic entitlement to seniors; others insisted that the Program remain voluntary.

These were just a few of the issues in dispute when the Program was created back in 1965. Ultimately, however, these issues were resolved, and the basic structure of Medicare—that remains today—was created.

As part of the legislative compromise in 1965, it was decided that Medicare should essentially reflect the private insurance model of that time. Consequently, since private insurance was often separated into hospital insurance and physician insurance, that concept was included in the legislation. Hospital insurance was called Part A and physician insurance, Part B. At the time, that idea, along with many others included in the Medicare law, made sense because they were reflective of how people believed health care services should be managed back in the 1960's.

Today, our health care system is considerably different from that of 1965. So we need to ask ourselves: is there a better way to design this program so that it reflects a 21st Century model of managing health care services. How can we best change this design model—an essentially static one for 35 years' and modernize it for today's seniors?

I don't have all of the answers to these questions.

But one thing we can say with certainty: many of the assumptions that were used to design the Medicare Program in 1965 are no longer valid. For example, private insurance no longer separates inpatient hospital coverage from physician services; beneficiaries don't have separate deductibles for hospital inpatient and physician services in the private sector; and significantly, prescription drug coverage is no

longer considered a luxury, it's an integral part of a patient's treatment regimen. Medicare may still be operating under a 1960's model, but we are now in the 21st Century.

Today, we must begin to discard some of the relics of the 1960's, including many of the current distinctions between Medicare Parts A and B. This division no longer reflects the needs of Medicare beneficiaries, both in terms of financing and cost-sharing structures.

Here are just a few oddities of the existing A/B structure:

Medicare's Part A deductible is \$792 per admission, and increases every year. By contrast, the Part B deductible is \$100 and has not been indexed for inflation in ten years. Private insurance employs a unified deductible. Why shouldn't Medicare?

The Medicare Part A Trust Fund is expected to go insolvent in 2029. Part B, on the other hand, will never go insolvent because an ever increasing amount of general revenue dollars will flow into the Program. Isn't it more prudent to measure the long term financial viability of the Program by looking at Parts A and B together?

Because of the distinctions between Medicare Parts A and B, it is extremely difficult for the Program to implement comprehensive disease and case management strategies that focus on the total services provided to a beneficiary. Shouldn't we have a system that can effectively track when patients leave the inpatient hospital setting and move to an outpatient setting?

Claims processing is currently performed by fiscal intermediaries for Part A services and carriers for Part B services. Why shouldn't A and B claims processing functions be combined and performed by one contractor? By eliminating the distinction between fiscal intermediaries and carriers, we will be better able to reduce the number of contractors from fifty to ten.

Partially because of the separate program parts and the widely disparate cost-sharing structures, Medicare currently does not place a cap on beneficiary liability. Shouldn't the system be reformed so that Medicare beneficiaries are better protected from liability for prolonged illnesses?

These are just some of the issues that our Committee has been thinking about on the important question of whether to merge Parts A and B. We may hear today from some opponents of structural change that many of these suggested reforms can be accomplished without merging the Program. In some cases, that may in fact be true.

But ultimately, we at this Committee, should ask ourselves a more fundamental question. If we had the opportunity to design a new, more modern Medicare Program, would we maintain the existing distinctions between Parts A and B? Wouldn't we all want to create a more unified program reflective of how health care is managed in the 21st Century?

I think most of us in this room know the answers to these questions.

Mr. Chairman, thank you very much for bringing this important issue to our attention and focusing on some of the deficiencies in the existing system. I look forward to hearing from our distinguished witnesses today and yield back the balance of my time.

Mr. BILIRAKIS. And I thank the gentleman. Mr. Pallone, to make an opening statement.

Mr. PALLONE. Thank you, Mr. Chairman and Mr. Brown for holding this hearing. I want to express my concern over the issue that we are discussing today, and that is merging part A and part B of the Medicare program into one benefit package. I understand that we will be hearing arguments in favor of merging the two trusts funds, the hospital insurance trust funds and the supplemental insurance trust funds, much like the arguments we hear when discussing the Breaux-Frist Medicare reform proposal.

When we talk about Breaux-Frist, the argument is made that redefining solvency by measuring the combined status of trust funds will make Medicare's financial status more clear. The President's budget has already endorsed this policy because it would help lawmakers reduce the amount of general revenues allocated to the Medicare program. But I am opposed to these arguments in favor of Breaux-Frist, and I oppose merging the HI and SMI trust funds for several reasons. At a time when millions of our seniors and

Medicare are financially strapped due to the rising cost of prescription drugs, any rise in the cost of the Medicare program would be financially detrimental to seniors nationwide.

If both parts, A and B of Medicare are combined, it seems clear that seniors would face a higher deductible. This is only because of 15 percent of seniors utilize part A services and an overwhelming 85 percent of seniors use part B services in a given year. Combining these two parts will surely present beneficiaries with a higher deductible, placing an additional unnecessary burden on seniors who are already paying an average of about \$3,000 out-of-pocket cost for health services. This would only be exacerbated further by the fact that most seniors would see a rise in premiums for their supplemental insurance policies. Many of these policies pay for part A and part B co-insurance and deductibles, and if these costs increase for merging the two parts, it is likely that employers and beneficiaries will both have to make up the difference in cost.

Mr. Chairman, I just want to express my concern over asking beneficiaries to pay more out-of-pocket than they already do. We hear every day from our constituents about how they cannot pay for their prescription drug and we are working hard in this Congress to come up with a solution to this problem. The last thing we need at this point is to merge the HI and SMI trust fund, thereby increasing the cost of Medicare before we even add a prescription drug benefit. There are a lot of important questions we need to ask in this discussion of merging the two trust funds and how a combined program would be financed, but I just want to stress the cost to seniors and the solvency of the Medicare program should be the top priority. Thank you.

Mr. BILIRAKIS. I thank the gentleman. Dr. Ganske for an opening statement.

Mr. GANSKE. Thank you, Mr. Chairman, I will be brief. I would like to read a section from the staff memo on this hearing. If parts A and B were combined, there may be increased pressure to use general revenues to cover shortfalls, particularly as the number of working contributors declines and the number of baby boomers begins to retire. Therefore, most proposals to merge parts A and B of the Medicare program include an overall limit on general revenue expenditures. Such a cap would be controversial. I would say, Mr. Chairman, that would be an understatement.

It goes on to say opponents to merging parts A and B suggest that a cap on general revenues would restrict available services and increase beneficiary cost-sharing liability. And I think that very well may be the case. I think, Mr. Chairman, we need to face up to the fact that when the baby boomers were starting to go to school, the Nation decided to build more schools to cover the cost of their education. Baby boomers are retiring, and we are more and more going to be entering into the needs for health care. And to set some type of arbitrary number on the amount of expenditures for health care based on, say, a percent of GDP, I think, would be very problematic for this Congress, and we need to face up to the fact that because of demographics, we are going to be facing increased health costs in the not-too-distant future. In fact, in the year 2012, baby boomers will start to retire and we will see one new retiree every 8 seconds.

I think it is important to look at how the Health Care Financing Administration is functioning to make sure it functions as efficiently as possible. I think we also need to be very careful when we are talking about some very, very significant changes in the structure of the Medicare program. With that I yield back.

Mr. BILIRAKIS. I thank the gentleman and certainly concur in his statement. Ms. Capps for an opening statement.

Mrs. CAPPS. I will yield my time to Mr. Waxman.

Mr. BILIRAKIS. We will yield to Mr. Waxman.

Mr. WAXMAN. I want to thank you for holding this hearing Mr. Chairman. I want to thank my two colleagues for being so courteous as to let me go ahead, because I have to go to another subcommittee of another committee, and others have to do it as well, but they have been very nice to defer to my seniority and age.

As we approach this hearing today, there is a fundamental question that is bothering me. What is our goal here? What precisely are we trying to achieve? I make this point because the topic, combining parts A and B of Medicare, gives us little clue to what precisely is proposed, and indeed, depending on how that question is answered, what is the impact on the structure of the program, it's fiscal health and—most importantly—the millions of Medicare beneficiaries.

I have puzzled over what precisely people mean when they talk about this merger. Yes, we could make Medicare follow the structure of more traditional insurance models. Clearly today, unlike when Medicare was established, private insurance would no longer be split into two separate products, one for hospital coverage, one for physicians and other outpatient services. But simply saying that has no bearing, really, on whether there are reasons to change Medicare. We have a program that currently has two separate financing structures—payroll deductions placed in the Medicare hospital insurance trust fund for part A and premiums and general revenues for part B. If we combine the parts of the program, would we use up the trust fund revenues and further destabilize Medicare's financing? Is the goal to limit the general revenue contribution and shift more of the cost to the beneficiary?

In the current program, we have automatic coverage for hospital services without additional payments for part A, but voluntary enrollment in part B does require the payment of a premium. Would we take away the automatic eligibility for hospital coverage if the premium wasn't paid? Would you require mandatory participation in part B, whether or not you have other coverage or whether or not you could afford the premiums?

In the current program, we have separate deductibles in parts A and B. What would it mean if we combine the two programs? Would there be a single deductible? Is that the intention? Are we going to combine them and inevitably increase the out-of-pocket expenditures for the average Medicare beneficiary?

In the current program, we have intermediaries who have developed great expertise in dealing with hospitals and carriers who traditionally deal with doctors and other outpatient service. Would combining them affect the services provided?

Right now Medigap coverage is built around the system as it is. Do we have any idea what this change would mean for the cost and availability of Medigap?

And finally, is there anything in the change that would address the major deficiency in Medicare, the lack of prescription drug coverage?

To me, this looks like, this hearing, this idea of merging these two parts of the program, looks like a solution in search of a problem. So I hope as we approach this hearing, we will be keenly aware that what looks like a simple change on paper in the design of law would have many complex effects in the real world. To make these changes without certainty that the beneficiaries of this program would be better off seems to me to be the ultimate in folly. Thank you very much.

Mr. BILIRAKIS. Mr. Pitts for an opening statement.

Mr. PITTS. No opening statement.

Mr. BILIRAKIS. Mr. Deal for an opening statement.

Mr. DEAL. Thank you, Mr. Chairman. Mr. Chairman, I share some of the concerns that have been expressed by colleagues on both sides of the aisle. But my primary concern relates to the overall programs and our ability to pay for them. One of the advantages we have had in having the part A and part B separated is at least into part A, we have had the fiscal discipline of a dedicated revenue stream of a portion of the FICA tax, because that is a dedicated revenue stream and is therefore finite, based on the number of people working and paying into the system and the potential bankruptcy of that revenue stream that led to such reforms as we found in the 1997 Balanced Budget Act in order to keep the program solvent for a longer period of time. My concern is that if we lose an attachment to a paying source such as FICA tax and become more and more dependent on the general revenue of this country, it leads us in a very dangerous direction.

For one thing, I think it lends itself to the argument that after all, total health care cost is the responsibility of the anonymous government, without realizing that the government is, in fact, us. It is very easy in this day and time of demanding more and better health care, that that is more and more expensive, that we expect someone else to pay for it. I am concerned that a merger might lead us further and further in the direction of saying that we need no link whatsoever to a dedicated revenue stream, and therefore look totally to the general revenues of this country to pay for it.

That may sound good in many people's ears, but I think it is a direction that the originators of Medicare did not want us to go, because it more and more will place Medicare in the posture of a welfare program rather than a program that is dependent on a dedicated known quantity of a revenue stream.

And if that revenue stream is not sufficient, then obviously the way to do a that is to raise the FICA tax to create a revenue stream. But quite honestly, I think all of us know that neither side of the aisle has advocated that as a solution to the problem. Nor do I expect that to be the advocated solution in the near future.

Thank you, Mr. Chairman.

Mr. BILIRAKIS. I thank the gentleman.

Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. And I want to thank you for holding our second hearing this week of the subcommittee. It is good to be on an active subcommittee. This hearing to discuss the feasibility of merging Medicare parts A and B. It is probably fair to say that no one on this panel, or maybe in this room, unless you are in Medicare, has one insurance policy for hospital stays and another insurance policy for doctors' visits. We probably all have one policy with one deductible. Our Medicare system, however, was formed in just this manner, two different plans for different types of health care. And under our staff memo, it was formed because of the opposition of physician groups in 1965. And I remember those notices in my doctor's office, even when I was 14, 15 years old, saying we are going to have socialized medicine under Medicare. But now, that physician really believes in Medicare. We wouldn't recreate this model 35 years later any more than we would create a Medicare system today that would not have a prescriptions drug benefit.

However, merging the programs is harder and is not so simple. Issues surrounding financing, participation, cost sharing, and payment method all needs to be resolved before we can consider the merger of the two. And in this context, we must ask ourselves what are the goals for the Medicare program and would merging parts A and B achieve those goals?

At a minimum, I believe the goals for the program should be to improve access to the program, and ensure that costs are controlled. So what would merging the two programs do to achieve these goals? We have held several hearings about the agency shortcoming with regard to making coverage decisions, its ability to educate providers about coding and payment procedure and its customer service operations.

Merging the program would eliminate some of the confusion surrounding these issues and can make it easier for beneficiaries and providers to use the system. Merging payment and delivery services would also improve disease management services, coordination of care and other important qualities issues. However, merging these programs would create a whole new set of access questions for beneficiaries. For example, the current deductible for Medicare part A is \$792 dollars. The current deductible for part B is \$100. While most beneficiaries meet their part B deductible, only 15 percent meet their part A deductible.

By combining these programs, we would raise the part B deductible, increase out-of-pocket costs for most beneficiaries, but not increase their benefits. As seniors who are already spending more than \$3,000 in out-of-pocket costs, we should think carefully about increasing the burden. Also we must consider whether the merger of part A and B would improve the long-term health of the Medicare program or include some of the costs associated with the program. With only 2 percent of the program funds currently to be used for administration, it is unlikely that merging A and B would achieve any real significant administration savings.

Most of our witnesses agree that merging the program would not significantly extend the program's solvency. Before we start making substantial changes in the Medicare system, it is imperative that we answer the questions. We should not change the program just

for the sake of change, just like we shouldn't change a name without structural reform.

Mr. Chairman, I don't have the answers to these issues, but I have lots of questions and I yield back my time and I look forward to the witnesses, thank you.

Mr. BILIRAKIS. Thank you, Mr. Green.

Let us see, Mr. Bryant to make an opening statement.

Mr. BRYANT. Mr. Chairman I took look forward to hearing from this panel of witnesses, and to that end I would yield back the balance of my time.

Mr. BILIRAKIS. I thank the gentleman. Ms. Capps .

Mrs. CAPPS. Thank you, Mr. Chairman. I am pleased that we are carefully examining the possibility of merging part A and part B of Medicare. This idea has been floating around out there for some time, but it is very complex and should not be easily accepted. If we do not adequately review it and its consequences before trying it out, we may do more harm than good. We want to keep in mind that Medicare is a sacred program to today's seniors. They count on it and we want to make sure they can count on it in the future. It is the most successful government health program in history. It has assured the availability of health care for millions of older Americans who previously had no options. We as a society have made a pledge to them that they will have health care so we need to follow through on this pledge.

So it is absolutely essential that we not damage the program as we look to improve it. Any form of Medicare must meet certain requirements. It cannot cut benefits that seniors count on. It cannot increase the cost to our seniors, especially when they are still paying for their own prescription drugs. And it cannot jeopardize the existence of the program itself. Proponents of merging the two parts often see it as a miracle cure for the challenges Medicare faces, but there are too many variables for it to be any kind of miracle. For example, many supporters claim that merging the trust funds would give us a more accurate view of Medicare solvency. But they fail to mention that the two parts were designed to have different definitions of solvency. Part A was meant to be a program that remained solvent financing itself mostly with dedicated payroll taxes. But part B is a more traditional government program without a specific source of funding beyond the U.S. Treasury and premiums collected from beneficiaries. It was meant to be dependent on an annually fluctuating level of general revenues.

So merging the trust funds would change the underlying assumptions about financing Medicare and could allow Medicare's opponents to handicap the program by capping or cutting off general revenue funds.

Another questionable element of the merger is its effect on cost-sharing mechanisms. Right now, part A has a much larger deductible than part B, and part B requires 20 percent co-insurance and has an annual premium. Merging them would probably lead to a deductible between the two and possibly more costs sharing for part A services, because in a given year most beneficiaries pay the part B deductible, but probably do not need to pay the part A deductible, this merger would mean a high cost for most of them.

These are some of the many difficult policy implications that we need to really understand before we try to implement this proposal. Mr. Chairman, I hope that if this proposal is being seriously considered, that this will be the first of many hearings so that we can be assured that we understand all of the ramifications. So I look forward to working with you on this issue and am eager to hear what the panelist have to say. I yield back.

Mr. BILIRAKIS. Thank you. Mr. Stupak for an opening statement.

Mr. STUPAK. Thank you, Mr. Chairman and thanks for holding this hearing on the implications of merging parts A and B of Medicare. I believe it is the duty of this subcommittee to monitor and take necessary action to improve our Nation's health care system of which Medicare plays a very large role. The most contentious issue is the combining of part A trust fund with part B trust fund and how this combination would affect the solvency of the program.

Currently, Medicare solvency is measured by the status of the H-I, or part A trust fund. As of March, the Medicare trustees estimate that the H-I trust fund will be solvent until 2029, the longest period of solvency in Medicare history. So the question must be asked, do we want to jeopardize the solvency that we in Congress have worked so hard to achieve? Combining the two trust funds would force the Medicare program into insolvency more quickly, although some have argued it would provide a more complete picture of Medicare's financial status.

Another factor that must be considered in merging is the administrative angle. Is this merger designed to save money on administrative costs? HCFA's administrative budget has been slashed to keep their administrative costs running at below 2 percent. What resources are left to implement these changes? Wouldn't this money be better spent improving the existing system and not in tearing it down and rebuilding it all over again? Who would this restructuring help? Certainly not the beneficiaries who Medicare was specifically set up to assist. Merging A and B would most certainly result in a higher deductible, and this for seniors who already spend an average of over \$3,000 a year in out-of-pocket health care expenditures, including prescriptions drugs, make this proposal unaffordable.

There are also so many policy questions tied up in restructuring that I simply do not see the point. For example, would there be a new combined deductible? This would be unfair to those seniors who do not participate or who do not use the part A inpatient hospital portion. And would enrollment in a new improved Medicare combined program be mandatory as part A participation is now? How would a premium be set? How would the part B cost sharing requirements be applied to the part A services?

I am in favor of Medicare reform, Mr. Chairman, but let us make it meaningful reform and not a Band-Aid approach designed to make ourselves feel good that we have done something. If we are going to spend money on overhauling Medicare, let us concentrate our efforts on such things as catastrophic coverage or prescription drug coverage. These are real reforms, and real reforms actually touch people's lives and improve the quality of living. Let us improve the existing program but not create an entirely new monster.

Thank you, Mr. Chairman I yield back my time I look forward to the testimony today.

Mr. BILIRAKIS. Let the record show the gentlelady from New Mexico was here and has left for a vote. I believe that takes care of the opening—I am going to cutoff the opening statement at this point then. And without objection the opening statements of all the members of the subcommittee will be made a part of record.

[Additional statements submitted for the record follow:]

PREPARED STATEMENT OF HON. ELIOT L. ENGEL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF NEW YORK

Mr. Chairman, I want to thank you for having this hearing and continuing to examine different ways to improve Medicare for seniors. Today's hearing focuses on combining parts A and B of Medicare and the implications that it will have on the program's services, costs, and trust funds. However, we must consider this issue in a broader light of providing a prescription drug benefit under Medicare and possibly modifying the administrative process at the Health Care Financing Administration. These are all issues that this Committee has focused on earlier in the year. All of these considerations must be examined if there is to be a true Medicare reform bill. To do less would be an injustice to the millions of seniors who rely on Medicare.

Medicare was created to provide seniors with affordable access to high quality health care. It was enacted to prevent seniors from losing their life savings when they become sick late in life. As President Johnson signed the Medicare legislation into law, he said "No longer will illness crush and destroy the savings (seniors) have so carefully put away over a lifetime so they might enjoy dignity in their later life... No longer will this nation refuse the hand of justice to those who have given a lifetime of service and wisdom and labor to the progress of this progressive society." The 89th Congress had the pleasure of designing the Medicare program which has endured many changes over the years. However, this Congress may be faced with the most significant challenge since Medicare's inception. Not only do we intend to provide a prescription drug benefit but are also undertaking the enormous challenge of reforming and modernizing the Health Care Financing Administration and the Medicare program as a whole.

As this and other Committees study different reform models that combine Parts A and B with new cost sharing and benefit structures, streamline the administrative process, and alter the current financing structure of the Trust Funds, we must keep in mind that this is a program designed for our elderly. It must remain affordable, it must maintain a high level of care, and it must allow seniors to live with dignity.

I understand the complex changes that the delivery of health care has endured over the last 35 years and realize that we need to take a good hard look at the Medicare program. Seniors deserve high quality care and if changes are needed we need to make them. I look forward to today's testimony. I want to thank the witnesses for their time and effort in coming to this hearing. And I want to assure you Mr. Chairman that this is an issue of great importance to me. I have had personal experience with the complexities in dealing with Medicare. However, Medicare is essential to the health of our elderly population. I am pleased we are examining this issue and hope that we can use the information gathered today in a constructive manner.

PREPARED STATEMENT OF HON. JOHN D. DINGELL, A REPRESENTATIVE IN CONGRESS
FROM THE STATE OF MICHIGAN

Chairman Bilirakis, I am pleased that the Health Subcommittee is conducting this hearing on Medicare reform. The Subcommittee will examine many important and complex questions today, such as how to reduce the coinsurance that seniors with lengthy hospital stays must pay and how to improve the administration of the Medicare program. I would caution my colleagues, however, not to jump to the conclusion that merging Parts A and B of the Medicare program is the only way to achieve these goals.

We can improve Medicare coverage of catastrophic expenses without necessarily combining Parts A and B. We can give the Health Care Financing Administration (HCFA) the flexibility to contract with one entity that can process both Part A and Part B claims. We can reduce the complexity of the program for seniors by increasing the funding in beneficiary education programs. In fact, even if we were to merge

Parts A and B of Medicare, it would do nothing to accomplish these objectives without a corresponding commitment from Congress to increase the resources that HCFA has to administer the Medicare program.

When discussing whether to merge Medicare Parts A and B, the most important question is how will it affect the millions of Americans who depend on this program for their health care, most of whom are living on fixed incomes and are already spending a significant portion of their income on health care costs.

For that reason, we should acknowledge that the most important thing we can do today to improve the Medicare program is to add a meaningful prescription drug benefit that is available and affordable for every beneficiary. Before we embark on a long and contentious debate about Medicare reform, Congress should show seniors that we hear their most immediate concerns, and respond by creating a universal prescription drug benefit in Medicare.

I look forward to hearing today's witnesses, but I also eagerly await the opportunity to move forward on the reform that we all agree is most urgently needed: Medicare prescription drugs.

Mr. BILIRAKIS. I ask the panelists to come forward and we will break because we have two votes on the floor. We have a vote on the previous question and a vote on the rule. So it should take us approximately a half an hour, I am guessing. Thank you very much.

[Brief recess.]

Mr. BILIRAKIS. Well, the hearing will come to order. Thank you for your indulgence. The witness list consists of Dr. William J. Scanlon, director of health care issues with GAO. Dr. Scanlon you have been here many times and we appreciate it, sir. Dr. Donald Young is chief operating officer and medical director of health insurance association of America. Doctor, welcome back. Mr. Don Schulder is an executive legislative director of the alliance for retired Americans. Ms. Marilyn Moon is the senior fellow with the Urban Institute, and Ms. Kathy Means, as I mentioned earlier, is senior health policy advisor to Patton Boggs located here in Washington, DC.

I suppose all of you have submitted written statements. I have not had a chance to look at them all. But your written statement is a part of the record and we would hope that you would complement or supplement it, if you would. I am trying to decide here. We will set the clock at 5 minutes, but certainly not cut you off if you are going to go over a minute or two or whatever the case may be there. I know it is the only panel and we do want you to have an opportunity to present whatever statement it is you want us to hear. So we will just set it for the purposes of having something but not adhere to it too strictly.

Dr. Scanlon please proceed, sir.

STATEMENTS OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES, U.S. GENERAL ACCOUNTING OFFICE; DONALD A. YOUNG, CHIEF OPERATING OFFICER AND MEDICAL DIRECTOR, HEALTH INSURANCE ASSOCIATION OF AMERICA; DANIEL J. SCHULDER, LEGISLATIVE DIRECTOR, ALLIANCE FOR RETIRED AMERICANS; MARILYN MOON, SENIOR FELLOW, THE URBAN INSTITUTE; AND KATHLEEN E. MEANS, SENIOR HEALTH POLICY ADVISOR, PATTON BOGGS

Mr. SCANLON. Thank you very much, Mr. Chairman, Mr. Chairman, Mr. Brown and members of the subcommittee. I am very pleased to be here today as you continue to consider how the Medicare program might be modified to better serve beneficiaries, pro-

viders and taxpayers. Medicare reform discussions have focused on how to modernize the program, as you have heard, that has been patterned after 1960's era private insurance. Back then, different policies for different services were the norm, and insurers were passive bill payers that did not try to influence how care was delivered. While private insurers have moved on, Medicare still has two distinct parts, parts A and B, and the traditional fee-for-service program remains primarily a passive bill payer.

Viewing Medicare in its entirety could promote the use of a more comprehensive and accurate measure the programs fiscal health. The program's fiscal well-being has generally been gauged by the projected solvency of trust funds that are expected to grow as a share of total spending. A variety of alternative measures could provide a more complete picture. For example, the Medicare trustees already report total program spending as a share of gross domestic product. Having a more complete measure is a first step. Establishing a threshold to trigger action to rebalance revenues and spending when needed is an equally important consideration.

The comptroller general has urged the adoption of comprehensive measures and associated triggers, but the need for them would be more acute if the trust funds were unified because a merger would remove the powerful signal that impending part A insolvency has provided. Unification of the trust funds would raise issues regarding the sources of financing and beneficiary eligibility, as you have heard. What mix of payroll taxes, general revenues and benefit premiums to use to pay for the program would have to be determined. A new formula for computing beneficiary premiums would need to be specified.

And finally, whether eligible persons could only participate in the entire program by paying premiums or whether the entitlement to some services by virtue of having paid the payroll tax would be maintained would also need to be resolved. A more comprehensive view of the program could also facilitate development of better cost sharing requirements. Health insurers today commonly design deductibles, co-insurance and co-payments, to make beneficiaries aware of costs and to encourage prudent service use. Medicare's current cost sharing structure does not do that. For example, Medicare imposes a relatively high deductible for hospital admissions which are rarely optional but no cost sharing for home health services, which may be more discretionary. And unlike most private insurers, Medicare does not protect beneficiaries from high out-of-pocket costs, ignoring the effects of Medicare not covering an important service like prescription drugs.

Today many Medicare beneficiaries face substantial out-of-pocket costs on services Medicare does cover, 3.4 million spend more than \$2,000, and 750,000 beneficiaries spent more than \$5,000 on Medicare-covered services in 1997, the latest year for which such data are available. Trading less first-dollar coverage for better catastrophic protection has been suggested as a way to make Medicare provide more real insurance. While such a tradeoff might be generally acceptable, it would be important to consider appropriate protections for low income beneficiaries so that costs do not become a barrier to needed services or an undue burden. Restructuring a relationship between parts A and B will not solve problems HCFA

faces in managing the traditional fee-for-service program more effectively by moving away from being a passive bill payer.

HCFA needs the capacity to merge part B and part A data to support timely pertinent analyses of the program, whether or not the parts are actually combined. HCFA lacks that capacity today, not because of the separate parts, but because of its outdated and inadequate information systems. Private insurers are using data better today to try and promote more targeted use of services and better health. Their efforts include targeted beneficiary education, preferred provider networks, and coordination of services.

Adopting some of these approaches could potentially improve Medicare, however consideration must be given to how to modify them for such a large public program, and they need to be tested adequately to understand their benefits and costs. HCFA has been taking some steps in this regard to better manage services beneficiaries receive. For example, it has been able to implement broad-based education efforts to try and increase the use of important preventative services, but private insurers go one step further and target education to individual beneficiaries, such as those who have not yet obtained a particular service.

If HCFA did something like that, beneficiaries and others might have serious concerns about large government using personal medical information in such a way. HCFA has also tested a type of preferred provider arrangement making single global payments to hospitals for all services, both part A hospital and part B physician services related to bypass surgery. The results were lower cost, lower mortality and more satisfied beneficiaries. However, broad application of such preferred provider techniques could evoke concerns about selection of providers and beneficiary choice. Essentially, initiatives like these to better manage services may not require a formal unification of parts A and B, but they raise important questions for you about some of the basic principals originally incorporated into the program. Namely, beneficiary freedom of choice, any willing provider participation, and minimal influence over service use.

The evolution of health care since 1965 makes it seem reasonable to ask whether changes at the margin in some of these areas would benefit beneficiaries and the program.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions you or the members of the subcommittee may have.

Mr. BILIRAKIS. Thank you, Dr. Scanlon. We didn't hustle you along there, did we? I intended you to present whatever information you had.

Mr. SCANLON. No, that is fine.

[The prepared statement of William J. Scanlon follows:]

PREPARED STATEMENT OF WILLIAM J. SCANLON, DIRECTOR, HEALTH CARE ISSUES,
UNITED STATES GENERAL ACCOUNTING OFFICE

Mr. Chairman and Members of the Subcommittee: I am pleased to be here today as you continue to consider how the Medicare program might be modified to better serve beneficiaries, providers, and taxpayers. Discussions about how to reform and modernize Medicare have, in part, focused on whether the structure that was adopted in 1965 remains optimal today. In that context, questions have been raised about the desirability of maintaining Medicare's division into two distinct parts, part A for hospital and other institutional care and part B for physician, outpatient, and other

noninstitutional services. This bifurcated structure is no longer common among private insurance, as it was in the 1960s when insurers marketed separate policies for different services.

Problems with financing beneficiary cost-sharing, and program management have been linked with the fragmented structure of the program. Yet merging parts A and B may not be the only way to make progress in addressing these problems. To assist the Subcommittee as it considers restructuring Medicare, my remarks today focus on how reforms based on a more unified view of the program might affect (1) program financing and assessment of the program's financial health, (2) cost sharing requirements, and (3) program management, including administration and promotion of quality care. These observations are based on previous and ongoing GAO work on Medicare and private sector insurance, as well as other published research.

In summary, rethinking the relationship between parts A and B may encourage use of a more comprehensive measure of Medicare's financial health. The commonly used measure, part A trust fund solvency, does not include the growing share of program spending on part B services. While a more complete picture of Medicare's financial health can be obtained in a number of ways, the desire for a better picture of the program's financial prognosis is one argument for a single trust fund. Establishing a single trust fund would require agreement on how funds from payroll taxes, general revenues, and beneficiary premiums would flow to the program. It would require consensus on what measure would be used to track program finances and spur action to increase revenue or curb spending when needed. It also would require assessment of whether different beneficiary eligibility standards, similar to those currently specified for parts A and B, would be maintained.

Rethinking the relationship between parts A and B also could facilitate development of better cost-sharing requirements. The current cost-sharing structure fails to promote prudent use of services and protect beneficiaries from high out-of-pocket costs. These concerns could be addressed under the current part A and B structure or a more unified structure. Unifying the program completely would require some beneficiaries who now have other coverage and are enrolled in only one part of the program to pay additional premiums for coverage they already have. It also would increase costs to the government for care that is now covered privately. Alternatively, partial benefits could be extended to those who chose not to fully participate in a unified program.

Rethinking the relationship between parts A and B would not fundamentally address challenges the Health Care Financing Administration (HCFA) faces in, efficiently managing the disparate services Medicare covers. HCFA's outdated information technology (IT) systems have hindered its ability to develop data to improve payment methods and the quality of care beneficiaries receive. Further, as a large public program, Medicare is limited in its ability to incorporate innovations that private insurers have used to influence care delivery. These include targeted beneficiary education, preferred provider networks, and coordination of services. The National Academy of Social Insurance (NASI) has reviewed these private sector practices and concluded that they could potentially improve Medicare. However, they would need to be tested to determine their impacts and evaluated to ascertain how well they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. Full implementation of many of these innovations would require statutory changes to the program.

BACKGROUND

At its inception, Medicare's design mimicked the structure of existing private insurance, which commonly included different policies for different sets of services. It also was designed, like private insurance at the time, as a passive bill payer that did not try to influence how care was delivered. In fact, because of concerns about the potential influence of such a large government program, the original Medicare statute requires that Medicare not influence providers' practice of medicine and gives beneficiaries access to all participating providers.

Medicare is administered by the HCFA, and pays for some \$200 billion in health care benefits each year for about 40 million elderly and disabled Americans. Individuals who are eligible for Medicare automatically receive Hospital Insurance (HI), known as part A, which covers inpatient hospital, skilled nursing facilities (SNF), certain home health, and hospice care. Beneficiaries generally pay no premium for this coverage, having previously contributed payroll taxes from covered employment, but they are liable for required deductibles, coinsurance, and copayment amounts. (See tables 1 and 2.)

Medicare-eligible beneficiaries may elect to purchase Supplementary Medical Insurance (SMI), known as part B, which covers physician, outpatient hospital, labora-

tory, and other services. Beneficiaries must pay a premium for part B coverage, currently \$50 per month, and are also responsible for part B deductibles, coinsurance, and copayments.

Most of Medicare's 40 million beneficiaries are enrolled in both parts A and B. However, approximately 2 million are enrolled only in part A. Another 400,000 are enrolled only in part B. Those enrolled in only one part of the program often have private insurance from an employer or other source to make up the difference.

Approximately 14 percent of Medicare beneficiaries enroll in Medicare+Choice plans. These plans include health maintenance organizations and other private insurers who are paid a set amount each month to provide all Medicare-covered services. Beneficiaries must be enrolled in both parts A and B to join these plans, which typically offer lower cost-sharing requirements and additional benefits compared to Medicare's traditional fee-for-service program, in exchange for a restricted choice of providers.

Table 1: Medicare Part A and Part B Coverage, Eligibility, and Funding

	Part A	Part B
Coverage ...	<ul style="list-style-type: none"> —Inpatient hospital —Skilled nursing facility (SNF) —Home health.¹ —Hospice 	<ul style="list-style-type: none"> —Physician services —Laboratory services —Outpatient hospital —Home health.¹ —Durable medical equipment
Eligibility ...	<ul style="list-style-type: none"> —Individuals and their spouses over 65 who paid the Medicare payroll tax for 10 years (40 quarters). —Individuals over 65 who paid the Medicare payroll tax for 30 to 39 quarters and who pay a \$165 monthly premium. —Individuals over 65 who paid the payroll tax for less than 30 quarters and who pay a \$300 monthly premium. —Individuals eligible for Social Security disability benefits. —Individuals with end-stage renal disease 	<ul style="list-style-type: none"> —Individuals over age 65, disabled, or with end-stage renal disease who pay a monthly premium (\$50 in 2001)
Funding	Medicare payroll taxes	Premiums cover 25 percent and general tax revenue covers 75 percent

¹ Part A covers up to 100 home health visits following an inpatient hospital or SNF stay. Part B covers other home health visits.
Source: Medicare & You 2001, HCFA.

Table 2: Medicare Beneficiary Cost-Sharing for 2001

	Copayments, coinsurance, and deductibles:
Part A services:	
Inpatient hospital	\$792 deductible per admission ¹ \$198 copayment per day for days 61 through 90 \$396 copayment per day for days 91 through 150 ² All costs beyond 150 days
Skilled nursing facility (SNF)	No cost-sharing for first 20 days \$99 per day copayment for days 21 through 100 All costs beyond 100 days
Home health	No cost-sharing 20 percent coinsurance for durable medical equipment
Hospice	\$5 copayment for outpatient drugs 5 percent coinsurance for inpatient respite care
Part B services:²	
Physician and medical	\$100 deductible each year 20 percent coinsurance for most services 50 percent coinsurance for mental health services
Clinical laboratory	No cost-sharing
Home health	No cost-sharing
Outpatient hospital	20 percent coinsurance for durable medical equipment Coinsurance varies by service and may exceed 50 percent

¹ No deductible is charged for second and subsequent hospital admissions if they occur within 60 days of the beneficiary's most recent covered inpatient stay.

²After the first 90 days of inpatient care, Medicare may help pay for an additional 60 days of inpatient care (days 91 through 150). Each beneficiary is entitled to a lifetime reserve of 60 days of inpatient coverage. Each reserve day may be used only once in a beneficiary's lifetime.

³No cost-sharing is required for certain preventive services—including specific screening tests for colon, cervical, and prostate cancer and flu and pneumonia vaccines.

Source: Medicare & You 2001, HCFA.

Medicare pays for services out of two separate trust funds. Part A services are paid for out of the HI Trust Fund. It is primarily financed through the Medicare payroll tax that is exclusively dedicated to this trust fund. Part B services are paid for out of the SMI Trust Fund. This trust fund is financed in part through the part B premium, which is adjusted each year to equal 25 percent of expected part B spending. The remaining 75 percent is paid for out of general tax revenues.

RESTRUCTURING RAISES FINANCING AND BENEFICIARY PARTICIPATION ISSUES

Medicare's two parts have distinct financing and participation arrangements. Modifying these arrangements could promote the use of a more comprehensive measure of Medicare's financial health and help policymakers anticipate future fiscal imbalances. In addition to selecting such a measure or measures, Congress could also decide to establish thresholds that would trigger corrective actions designed to rebalance Medicare revenues and spending. Unification of the now separate HI and SMI trust funds would require consideration of these issues, but even without such a merger, comprehensive financial measures and associated triggers would be useful. Unification would also require Congress to determine how the current mix of payroll taxes, beneficiary premiums, and general revenues might be modified to fund the program, as well as whether beneficiaries would be obligated to participate in the full program or could obtain coverage for subsets of services.

Focus on HI Trust Fund Provides Misleading View of Medicare's Financial Health

In the past, Medicare's financial status has been generally gauged by the projected solvency of the HI trust fund. Looked at this way—and based on the latest annual report from the Medicare Trustees—Medicare is viewed as solvent through 2029. Solvency is a popular measure, in part because the consequences of insolvency are clear. If there is no money in the HI trust fund, the government cannot pay hospitals or other providers of part A services. Thus, the threat of insolvency can be a powerful driver for action. In 1997, the Medicare Trustees estimated that the HI trust fund would become insolvent in 2001. The HI trust fund had not been so close to a crisis since 1972. Following the Trustees' 1997 report, Congress enacted the Balanced Budget Act of 1997, which contained substantial payment and other reforms designed to slow Medicare's cost growth. These reforms, coupled with a strong economy, helped to increase the life expectancy of the HI trust fund.

However, HI trust fund solvency is an incomplete measure of Medicare's fiscal health. It does not reflect the cost of the part B component of Medicare, which covers outpatient services and is financed through general revenues and beneficiary premiums. Part B accounts for more than 40 percent of current Medicare spending and is expected to account for a growing share of future total program dollars. The concept of solvency does not apply to the trust fund for part B, SMI, because increases in expenditures are automatically matched with increases in general revenues and beneficiary premiums.

In addition, HI trust fund solvency does not mean that Medicare's part A component is financially healthy. Although the trust fund is expected to remain solvent until 2029, HI outlays are projected to exceed HI revenues beginning in 2016. As the baby boom generation retires and the Medicare-eligible population swells, the imbalance between outlays and revenues will increase dramatically. Thus, in 15 years the HI trust fund will begin to experience a growing annual cash deficit. At that point, the HI program must redeem Treasury securities acquired during years of cash surplus. The government will then need to increase taxes, increase borrowing (or retire less debt), impose spending cuts, or implement some combination of these actions.

When part A expenditures outstrip payroll tax revenues, it may be tempting to reallocate some expenditures from part A to part B. This would extend the solvency of the HI trust fund, but would do little to improve Medicare's overall financial health. For example, BBA reallocated a portion of home health spending from part A to part B. Although that action—phased in over time—reduces HI expenditures and extends that trust fund's solvency, it also increases SMI expenditures. Consequently, the home health reallocation increases the proportion of Medicare funded by general revenues and beneficiary premiums.

Comprehensive Measures Could Better Indicate Program Sustainability

Clearly, it is total program spending—both part A and part B—which determines whether Medicare is sustainable over the long haul. Whether the program remains in its current configuration, or the relationship between parts A and B are restructured, a more comprehensive measure of Medicare's financial health could help Congress anticipate future fiscal imbalances. A variety of such measures exist now. For example, the Medicare Trustees report total Medicare spending as a share of gross domestic product (GDP). This measure clearly shows that total Medicare expenditures will likely consume an increasingly larger share of the national economy. Currently, combined HI and SMI expenditures account for 2.3 percent of GDP. This percentage is expected to rise to 4.5 percent in 2030 and 8.5 percent in 2075. Another comprehensive indicator measures Medicare spending relative to the entire federal budget. We estimate that Medicare's share of the federal budget will increase from 10 percent in 2000 to over 23 percent in 2030 if the program's spending growth continues unchecked.¹

Fiscal Measures Could Trigger Congressional Action

The adoption of new financial health indicators for Medicare would be one step; the next would be to decide what should trigger congressional action. Congress could agree that it would take action to rebalance Medicare spending and revenues whenever a comprehensive measure reached a predetermined level. Possible actions could include increasing general revenue contributions, payroll taxes, or beneficiary premiums; reducing benefits; cutting provider payments; or introducing efficiencies to moderate spending. The 1999 Breaux-Frist Medicare reform proposal provides one example of a potential trigger. Under that proposal, the two trust funds would be unified and congressional action would be required in any year when general revenue contributions exceeded 40 percent of total Medicare expenditures.

The need for measures of program sustainability and thresholds that would trigger congressional action would be most acute if the trust funds are unified. Such a reconfiguration could remove the powerful signal of the HI trust fund insolvency and reduce the apparent urgency of corrective actions. If the trust funds remain separate, comprehensive measures of Medicare's financial health and associated triggers could avoid the shortcomings that arise from a focus on the HI trust fund's solvency.

Improved measures of Medicare sustainability and agreed-upon thresholds will not, however, alter the difficult decisions facing this and future Congresses. A growing Medicare population and advances in expensive medical technology will increase future demands for health care spending. Policymakers will need to find ways either to control Medicare's spending growth or obtain additional revenues to pay for it. Any solution to address the financial imbalance will affect beneficiaries, taxpayers, providers, or some combination of the three groups. Better measures of Medicare's financial health may help identify the need for action, but will not lessen the difficulty of implementing a solution.

Unification of Trust Funds Raises Questions About Financing, Premiums, and Participation

Creating a unified trust fund for Medicare parts A and B would raise several new issues Congress would need to address. One is program financing—Congress would have to specify Medicare's revenue sources and the share that each source would contribute. Under the current arrangement, revenues come from the Medicare payroll tax, general revenues, and beneficiary premiums. Broadly speaking, the amount financed from each revenue source depends upon the amount spent on Medicare services and the classification of services into parts A and B. The payroll tax supports part A services. The amount of general revenues devoted to Medicare is set equal to 75 percent of part B expenditures. Beneficiary premiums are collected to pay for the remaining 25 percent of part B spending. If the trust funds were unified, Congress would have to specify the funding mechanism. It could, for example, determine the share that general tax revenues, payroll tax revenues, and beneficiary premiums would each contribute to total Medicare spending. Alternatively, it could adopt an allocation formula similar to the present one by designating some services to be supported by the payroll tax and others to be supported by general revenues and beneficiary premiums.

Beneficiary participation issues would also arise under a restructured program with a unified trust fund. Currently, about 2 million individuals (5 percent of beneficiaries) are eligible for Medicare part B but do not participate in the voluntary pro-

¹ Medicare: Higher Expected Spending and Call for New Benefit Underscore Need for Meaningful Reform (GAO-01-539T, Mar. 22, 2001).

gram. A smaller number of individuals do not qualify for coverage under part A, although provisions allow certain individuals to buy into the program by paying a monthly premium. Under a restructured program, Congress would need to determine beneficiary participation and premium options. For example, should participation in the full program and payment of any associated premium be mandatory? If full participation is mandated, program costs could increase and some beneficiaries would receive Medicare coverage for services covered by existing private policies. If full participation is voluntary, what coverage should be provided to those individuals who choose less than full participation? Would individuals who had made payroll tax contributions but decline to pay the premium not receive coverage? Or would reduced benefits—for example, coverage only for current part A services—be available for such individuals?

BENEFICIARY COST-SHARING COULD BE IMPROVED

Rethinking the relationship between parts A and B could facilitate rationalization of cost-sharing requirements and help make Medicare more like private sector and Medicare+Choice plans. Medicare's benefit design has changed little since its inception 35 years ago, and in many ways has not kept pace with changing health care needs and private sector insurance practices. Medicare's current costsharing requirements in particular are not well structured to promote prudent use of discretionary services. At the same time, they can create financial barriers to care and leave beneficiaries with extensive health care needs liable for high out-of-pocket costs.²

Cost-Sharing Requirements Are Not Well Structured

Health insurers today commonly design cost-sharing requirements—in the form of deductibles, coinsurance, and copayments—to ensure that beneficiaries are aware there is a cost associated with the provision of services and to encourage them to use services prudently. Ideally, cost-sharing should encourage beneficiaries to evaluate the need for discretionary care but not discourage necessary care. Optimally, cost-sharing would generally require coinsurance or copayments for services that may be discretionary and could potentially be overused, and would also aim to steer patients to lower cost or better treatment options. Care must be taken, however, to avoid setting cost-sharing amounts so high as to create financial barriers to necessary care.

The benefit packages of most Medicare+Choice plans illustrate cost-sharing arrangements that have been designed to reinforce cost containment and treatment goals. Most Medicare+Choice plans charge a small copayment for physician visits (\$10 or less) and emergency room services (less than \$50). Relatively few Medicare+Choice plans charge copayments for hospital admissions. Plans that offer prescription drug benefits typically design cost-sharing provisions that encourage beneficiaries to use cheaper generic drugs or brand name drugs for which the plan has negotiated a discount.

Medicare fee-for-service cost-sharing rules diverge from these common insurance industry practices in important ways. For example, as indicated in table 2, Medicare imposes a relatively high deductible of \$792 for hospital admissions, which are rarely optional. In contrast, Medicare requires no cost-sharing for home health care services, even though historically high utilization growth and wide geographic disparities in the use of such services have raised concerns about the potentially discretionary nature of some services.³ Medicare also has not increased the part B deductible since 1991. For the last 10 years the deductible has remained constant at \$100 and has thus steadily decreased as a proportion of beneficiaries' real income.

Beneficiary Liability Is Unlimited

Also unlike most employer-sponsored health plans for active workers, Medicare does not limit beneficiaries' cost-sharing liability. Employer-sponsored plans typically limit maximum annual out-of-pocket costs for covered services to less than \$2,000 per year for single coverage.⁴ In Medicare, however, current estimates suggest that the combination of cost-sharing requirements on covered services and the cost of services not covered by Medicare leaves beneficiaries liable for about 45 percent of their health care costs. The average beneficiary is estimated to have incurred

² Medicare: Cost Sharing Policies Problematic for Beneficiaries and Program (GAO-01-713T, May 9, 2001).

³ See *Medicare Home Health Care: Prospective Payment System Will Need Refinement as Data Become Available* (GAO/HEHS-00-9, Apr. 7, 2000).

⁴ The Kaiser Family Foundation and Health Research and Educational Trust, *Employer Health Benefits: 2000 Annual Survey*.

about \$3, 100 in out-of-pocket expenses for health care in 2000—an amount equal to about 22 percent of the average beneficiary's income.⁵ Some beneficiaries face much greater financial burdens. For example, low-income single women over age 85 in poor health and not covered by Medicaid are estimated to have spent more than half (about 52 percent) of their incomes on health care services.⁶

The average beneficiary who obtained services had a total liability for Medicare-covered services of \$1,451, consisting of \$925 in Medicare copayments and deductibles in addition to the \$526 in annual part B premiums in 1997, the most recent year for which data are available on the distribution of these costs. The burden of Medicare cost-sharing can, again, be much higher for beneficiaries with extensive health care needs. In 1997 slightly more than 3.4 million beneficiaries (11.4 percent of beneficiaries who obtained services) were liable for more than \$2,000. Approximately 750,000 of these beneficiaries (2.5 percent) were liable for more than \$5,000, and about 173,000 beneficiaries (0.6 percent) were liable for more than \$10,000.

Options for Addressing Cost-Sharing Concerns

Different approaches could be taken to address concerns about current costsharing requirements. Cost-sharing for less discretionary services could be reduced or eliminated. Catastrophic protection could be added to the benefits package. In addition, the part B deductible could be raised, or the part A and B deductibles could be combined.

Reducing or eliminating cost-sharing for less discretionary services, such as inpatient hospital care, could be done within the current program structure. Congress has already taken similar action by reducing and eliminating costsharing requirements for various cancer screening tests and vaccinations in order to ensure that affordability is not a barrier to these important services.

Adding catastrophic protection by capping how much beneficiaries are required to pay out-of-pocket also could be done under current program structure. There would need to be agreement on how to allocate between parts A and B the added cost to the program and recognition of the time and resources needed to incorporate such a change into HCFA's information systems.

Raising the part B deductible or creating a combined deductible for part A and part B services has been suggested to offset some of the additional cost of providing catastrophic protection. It would also offset some of the real-dollar decline in the part B deductible, which has not been adjusted for inflation or raised in any way since 1990. These changes could be done under current program structure as well, again with recognition of the time and resources needed to incorporate the change into HCFA's information systems. Most beneficiaries who incurred cost-sharing would likely meet a combined deductible through their use of what are now part B services. If the combined deductible is set higher than the current part B deductible, providing protection for low-income beneficiaries so that costs do not become a barrier to needed services or an undue burden would be an important consideration.

Combining the deductible or providing catastrophic protection would again raise the issue of whether to maintain individuals' ability to participate independently in A or B or to require full participation by all beneficiaries in the entire program. Requiring full participation for beneficiaries who now participate in only one part of the program could result in additional costs for beneficiaries who have alternative coverage as well as additional program costs. It also raises the issue of the entitlement for persons who have paid the required payroll tax, but choose not to pay the premium.

Partial benefits could be extended to those who do not fully participate in the program. Alternatively, some of the effects of mandatory participation could be muted by phasing in a unified program so that new beneficiaries would participate in the full program while those who now participate in only part of the program could continue to do so.

CHALLENGES FOR MANAGEMENT AND PROMOTING CARE QUALITY REMAIN REGARDLESS OF RESTRUCTURING

As noted earlier, the original Medicare statute reflected 1960s private health insurance practices that often included separate policies for different services as well as a passive bill paying approach. In contrast to Medicare, which has not changed much since its inception, private insurance has evolved over the last 40 years and

⁵ Stephanie Maxwell, Marilyn Moon, and Mesha Segal, *Growth in Medicare and Out-Of-Pocket Spending: Impact on Vulnerable Beneficiaries* (Urban Institute, Dec. 2000).

⁶ Maxwell, Moon, and Segal.

now offers comprehensive policies and employs management techniques designed to improve the quality and efficiency of services purchased. Private insurers are able to undertake these efforts because many have detailed data on service use across enrollees and providers, as well as wide latitude in how they run their businesses. Regardless of whether the relationship between parts A and B is restructured, HCFA faces challenges in seeking to more efficiently manage Medicare services due to its outdated and inadequate IT systems, statutory constraints, and the fundamental need for public accountability that accompanies a large public program. These limitations have hampered the agency's ability to administer the program and incorporate new innovations. Private insurers have taken steps to influence utilization and patterns of service delivery through efforts such as beneficiary education, preferred provider networks, and coordination of services. NASI has reviewed many of these private sector activities and concluded that they could have potential value for Medicare. However, they would need to be tested to determine their effects as well as how they might be adapted to reflect the uniqueness of Medicare as both a public program and the largest single purchaser of health care. In addition, HCFA would likely need new statutory authority to broadly implement many of these innovations.

Effective Program Management Depends on Comprehensive and Timely Information

To effectively oversee claims administration and assess the effects of innovative policies that private sector insurers have adopted, HCFA needs timely and comprehensive information on services and payments in the aggregate and for individual beneficiaries. HCFA lacks that capacity today, not because it has separate contractors for parts A and B, but because of deficiencies in its information systems. Some of the agency's vital information systems are decades old, with some operating software rarely used today by any entity other than HCFA, and lack the capacity and flexibility that newer technology can offer. Consequently, HCFA has had difficulty assembling timely and comprehensive information about provider billing patterns and beneficiary service use.

Currently, data from parts A and B do flow to some common points—both during claims processing and after. During claims processing, both part A and part B claims are checked through a prepayment validation and authorization system operated by HCFA—the Common Working File (CWF). Claims approved for payment are ultimately compiled in the National Claims History (NCH) Me, which can be analyzed to look at broader payment trends within the program. The problem is that this compilation of information occurs long after services have been delivered and claims paid.

These system limitations are unfortunate because changes in Medicare payment policy for one type of service can have reverberations in other areas. To understand these effects requires analysis across a range of services beneficiaries may be receiving. A clear example of this occurred after the implementation of a prospective payment system (PPS) for hospitals, which pays hospitals fixed, predetermined amounts for each hospital stay that vary according to patients' diagnoses. Prior to this innovation, hospitals were paid on the basis of their costs, with little incentive to limit patient stays or provide care efficiently. Paying a fixed amount for an episode of hospital care creates incentives for hospitals to reduce lengths of stay and to shift services that had been provided in the hospital to other settings. Understanding these modifications in care delivery led to payment changes to prevent Medicare from paying twice for the same service. More recent payment changes for home health and SNF services, and the soon to be implemented PPS for inpatient rehabilitation services, will likely cause similar kinds of care shifts. It is essential that HCFA has the ability to monitor changes in care delivery in a timely and objective manner to determine how these payment policies may need to be adjusted in the future.

Recent experience has also demonstrated HCFA's difficulties in developing information to measure the effects of changing Medicare policies on beneficiaries and providers in a comprehensive and timely manner. The Balanced Budget Act of 1997 (BBA) payment reforms represented bold steps to control Medicare spending by changing the financial incentives for delivering care efficiently. Reforms affected hospitals, home health agencies, SNFS, and providers of other services. Affected providers presented anecdotal evidence asserting that the BBA's payment reforms caused them financial difficulties and would impair beneficiary access, urging Congress to undo some of the act's provisions. HCFA analysts were ill-equipped to assess the validity of these charges because the necessary program data were not readily available.

Better and more timely information is a prerequisite to more effective program management. It is essential to the development and refinement of payment methods

for different service providers. It can also help policymakers understand the desirable and undesirable consequences of changes on beneficiaries, providers, and the trust funds. Generating these data is not dependent on unifying part A and part B, but rather on merging part A and part B data in a modern information system capable of supporting timely, pertinent analyses.

Quality Promotion Efforts Could Reap Benefits But Face Many Obstacles

An expert panel convened by NASI has suggested that Medicare may benefit from moving away from its passive bill paying approach by adopting some private insurers' practices designed to improve the quality and efficiency of care.⁷ The panel focused on provider and beneficiary education, preferred provider networks, and coordination of services as potential improvements in Medicare. Educating beneficiaries or providers could improve the use of important preventive and other services currently being under-used and minimize questionable use of services. Developing a system of preferred providers selected on the basis of quality as well as cost could improve care and help achieve savings. More actively coordinating care across provider settings for beneficiaries with chronic diseases like diabetes or who have recently experienced heart attacks might also help improve quality and efficiency. HCFA has begun to implement some innovations and experiment with others. Broadly implementing the experimental innovations that prove successful may require new statutory authority. Other private sector innovations, however, may be difficult to incorporate, given Medicare's size and the need for transparency in a public program.

HCFA has been able to implement broad-based education efforts but has been stymied in implementing approaches targeted to individual beneficiaries most likely to need the help. For example, it has an extensive effort underway to encourage colon cancer screening that includes dissemination of more than 23,000 innovative posters. The posters include tear-off sheets that beneficiaries can hand to physicians to facilitate discussions that otherwise might be avoided because of the unfamiliar words, sensitive issues, and unpleasant options that can be involved. HCFA is also involved in a multifaceted effort to increase flu vaccinations and mammography use among beneficiaries. However, HCFA may be less able to undertake more targeted education efforts that some private insurers are using, such as sending out reminders to identified enrollees about the need to obtain a certain service. Because of Medicare's size and status as a federal program, beneficiaries and others might have concerns about HCFA using personal medical information from claims data to target educational efforts. Providers might also object to a government insurance program advocating certain medical services for their patients.

HCFA is providing more information to physicians about service use and typical practice patterns in an effort to educate them about how their practice patterns compare to the norm. For example, the Medicare peer review organizations encourage those who have unusual practice patterns to reconsider their service provision. However, private insurers can go one step further and terminate providers who continue to have aberrant practice patterns. HCFA's ability to terminate providers is much more limited because of statutory requirements intended to protect beneficiaries' choice of providers.

HCFA's ability to encourage use of preferred providers is also limited. The Medicare statute generally allows any qualified provider to participate in the program. HCFA has experimented with bundling payments for certain expensive procedures performed by designated providers. For example, it tested the impact of making single "global" payments to hospitals for all services—both hospital and physician—related to coronary artery bypass graft surgery. The hospitals chosen for the experiment were among those with the best outcomes for these surgeries.⁸ The experiment cut program costs by 10 percent for the 10,000 coronary artery bypass surgeries performed, and saved money for beneficiaries through reduced part B coinsurance payments. More important, compared to a group of beneficiaries not receiving this bundled care, beneficiaries who were treated in one of the selected hospitals had lower mortality rates, were more satisfied with the quality of the nursing care, and appreciated the simplicity of a single coinsurance amount. HCFA has begun a similar experiment at selected acute care hospitals, which involves bundling payments for hos-

⁷ *From a Generation Behind to a Generation Ahead: Transforming Traditional Medicare*, Final Report of the Study Panel on Fee-for-Service Medicare, National Academy of Social Insurance, Washington, D.C.: January 1998.

⁸ A number of studies prior to this experiment have found that hospitals with the greatest volume of these types of surgeries generally had better outcomes, in regard to mortality and complications.

pital, physician, and other health care professionals' services provided during a beneficiary's hospital stay for selected cardiovascular and orthopedic procedures.

However, more wide scale Medicare implementation of such hospital and physician partnership arrangements may be difficult. Providers have raised concerns about a government program designating some providers as delivering higher quality care than others. In addition, bundling services for hospitals and doctors added administrative burdens to the hospitals and took control of payments away from doctors. In the end, it is not the separation of parts A and B that would impede efforts to promote such preferred provider arrangements. Rather, it may be more deep-seated concerns about government promotion of certain providers at the expense of others that serve as a barrier to this and other types of preferred provider arrangements.

HCFA has also been conducting demonstrations to test how to better coordinate care for certain patients since the 1980s. In addition, BBA⁹ mandates that HCFA find budget neutral ways to test methods of coordinating a range of services for chronically ill beneficiaries in at least nine urban and rural sites. The law authorizes the Secretary of Health and Human Services to incorporate any components proven to be cost-effective into Medicare through regulations and to expand the number of demonstration sites.

While there is increasing interest in efforts to coordinate care, it is not clear that they are always cost-effective. Some experience in both the private and public sectors suggests that such efforts can improve quality and achieve savings. For example, the Group Health Cooperative of Puget Sound and PacifiCare teamed with a senior citizens center to offer supervised health promotion and chronic illness self-management interventions to chronically ill seniors. The intervention included meetings with geriatric nurse practitioners to develop individually tailored health promotion plans, medication reviews, classes, support groups, and volunteer mentors. Preliminary findings suggested that the case-managed group had fewer health problems and lower costs compared to a group that did not receive the services. However, other experiments, including those conducted by HCFA, have failed to demonstrate either quality improvements or cost savings. Furthermore, there would need to be statutory changes to implement different coordination approaches in Medicare if they involved coverage of new services, such as care coordinators, or involved control over the use of particular services or providers.

CONCLUDING OBSERVATIONS

The Medicare program faces many challenges. Clearly, the overarching issue is how to ensure that Medicare remains sustainable for future generations of beneficiaries. Meeting that challenge will involve difficult decisions that will likely affect beneficiaries, providers, and taxpayers. However, the financing issue should not obscure other important Medicare challenges. Medicare's current cost-sharing arrangements are not well designed to encourage the efficient use of services without discouraging necessary care. Moreover, the lack of catastrophic coverage can leave some beneficiaries liable for substantial Medicare expenses. Finally, some aspects of Medicare's program management are inefficient and lag behind modern private sector practices. Changes in Medicare's program management could improve both the delivery of health care to beneficiaries and the program's ability to pay providers appropriately.

Some view restructuring of the relationship between parts A and B as an important element of overall Medicare reform. Fundamentally, assessing the program as a whole is an important first step in addressing Medicare's challenges. Solutions to many of these challenges could be crafted without restructuring. However, restructuring may provide opportunities to implement desired reforms—with or without unifying the HI and SMI trust funds while undoubtedly raising issues that will have to be considered.

Mr. Chairman, this concludes my statement. I would be happy to answer any questions that you or members of the Subcommittee may have.

Mr. BILIRAKIS. Dr. Young, you obviously have quite a background in this subject, so we are eagerly awaiting to hear what you have to say.

⁹ Section 4016.

STATEMENT OF DONALD A. YOUNG

Mr. YOUNG. Thank you, sir. Chairman Bilirakis, Mr. Brown, distinguished members of the committee, I am Dr. Donald Young, interim president of the Health Insurance Association of America. I am very pleased to be with you here today to discuss Medicare reform. I was previously executive director of the Federal Prospective Payment Assessment Commission, ProPAC, the predecessor to MEDPAC, and before that, deputy director of the policy bureau of the Health Care financing administration. Given this background, I am familiar with the world of private insurance as well as the Medicare program. Medicare is obviously a very popular program, something HIAA's own research has confirmed. However, I believe that lessons from the private insurance industry's long history may be useful as you consider how to make the program even stronger.

When Medicare was enacted in the 1960's, it was patterned after existing private insurance programs. But while the private sector plans have changed to offer a variety of programs that improve the coordination and delivery of care, the Medicare fee-for-service program has remained in its original form. For example, today, many surgical procedures can be performed safely and effectively, both as part A inpatient hospital services, and as part B, ambulatory services, the same procedure. Medicare beneficiaries, however, face very different out-of-pocket costs, depending upon where the service is furnished. The resulting financial incentives may result in the beneficiary not receiving care in the appropriate setting, thereby adversely affecting quality of care.

In contrast, private health insurance policies usually cover a comprehensive array of health services, both in and out of a hospital, subject to a single annual deductible. This arrangement is easier for insured people to understand and more efficient to administer. Under this private sector approach, claims for services flow to a single responsible organization and inquiries by insured individuals and their caregivers likewise could be made to one party.

Among other things, this arrangement also facilitates disease management program. Disease management programs take a systematic approach to medicine that encourages patients to follow health promoting behaviors and promotes a strong patient-doctor relationship. These program not only enhance the quality of care, but they help reduce the need for hospitalization, emergency room department visits, and other services. While beneficiaries in the Medicare+Choice program have access to these programs, fee for service beneficiaries do not and Medicare's current structure would create major challenges in designing such programs. A single program with centralized records allows plans to efficiently update and maintain beneficiary coverage and claims files and to coordinate care.

These efficiencies result in reductions in the cost for providing health care and help in treatment options and health outcomes. This can only be carried out through the links between various claims the beneficiary may have.

Combining information about different types of service is also extremely important for fraud detection programs. For example, a claim for a physician's hospital inpatient visit can be compared to

the dates on which a patient was hospitalized or a claim for laboratory work can be linked to the office visit at which the patient was seen and sent for tests.

Recognizing the constraints of its current structure, Medicare has, through the years, attempted to break down the barriers between its separate parts. HCFA has conducted various pilot projects under its general demonstration authority or based on specific congressional mandates. Such programs have been very successful, demonstrating the flexibility and the design of care management and payment programs that is characteristic of private insurance programs. They have also been cost efficient for the Medicare program and its beneficiaries. But putting such programs in place now requires special legislative or regulatory authority, in part because of Medicare's outmoded design.

The Medicare program is in need of substantial reform. Obviously, combining Medicare Parts A and B into a single program would not, by itself, improve care coordination, disease management, program administration or oversight. But many of these reforms to work effectively, a necessary first step is to eliminate the separation of the program into two parts as private insurers did many years ago.

Thank you for providing me this opportunity to talk about Medicare reform from the perspective of the private health insurance sector. I would be happy to respond any questions you might have.

[The prepared statement of Donald A. Young follows:]

PREPARED STATEMENT OF DONALD A. YOUNG, INTERIM PRESIDENT, HEALTH
INSURANCE ASSOCIATION OF AMERICA

INTRODUCTION

Chairman Bilirakis, distinguished members of the Committee, I am Dr. Donald A. Young, Interim President of the Health Insurance Association of America (HIAA). I am very pleased to be here today to discuss the issue of Medicare reform, especially as it relates to the program's current division into two separate parts, Part A, Hospital Insurance, and Part B, Supplementary Medical Insurance. My past work history includes stints as executive director of the federal Prospective Payment Assessment Commission and deputy director of the policy bureau at the Health Care Financing Administration. Given this varied background, I am not only familiar with the world of private insurance, but also with the Medicare program, and I hope that my contribution today will be of value to the committee.

Medicare is obviously a very popular federal program, something that HIAA's own recent national survey confirmed. However, I believe that lessons from the private insurance industry's long history may be useful as you consider how to make the Medicare program even stronger.

When the Medicare benefits package was originally developed in the 1960s, it was patterned after existing private sector insurance programs. But, while private sector plans have changed to offer a variety of programs that are more efficient and consumer oriented, the Medicare program has remained in its original form. I will describe some of the improvements in chronic disease management that private insurers have put in place to improve quality. I will also describe increased efficiencies and cost savings that result from more effective use of patient care data and improved oversight for fraud and abuse. The introduction of similar improvements in the Medicare program is unnecessarily hampered by its current structure.

Medicare Part A, the Hospital Insurance Program, helps pay for inpatient hospital, skilled nursing facility, and hospice care services. Medicare Part B, Supplementary Medical Insurance, pays for physician, outpatient hospital, and a range of other services, including ambulatory surgical services, physical, occupational and speech therapy services, and durable medical equipment. Home health services are covered under both parts. Medicare Parts A and B each have separate deductibles, separate coinsurance and cost sharing policies, separate claims processing entities and separate appeals processes. Frequently there are also different payment

amounts for the same service furnished by Part A and Part B providers. There is certainly the potential for uncoordinated policy making and perverse incentives that can diminish quality of care and increase program costs and beneficiary spending.

Claims for inpatient hospital services go to contractors known as fiscal intermediaries, while claims for outpatient hospital services and physicians' services, including those provided during an inpatient hospital stay, go to a separate contractor, known as a carrier. Thus, Medicare beneficiaries with questions about the handling of their claims must often contact two separate entities. Relatively poor communication between fiscal intermediaries and carriers undoubtedly allows many lost opportunities to coordinate patient care; make the Medicare program user-friendly for patients, providers and practitioners; and identify and address waste, fraud and abuse.

THE PRIVATE SECTOR MODEL

In several important respects, Medicare's current structure has made it difficult for the program to keep pace with innovations implemented by private insurers—particularly those intended to improve the coordination and delivery of care. To put this in context, let me briefly trace the evolution of the private health insurance market.

Private policies covering hospital and medical expenses date back to the 1930s. The earliest policies only provided daily benefits for hospitalization. Later, separate policies provided fixed reimbursement amounts for various kinds of surgeries. In those days, innovation meant developing stand-alone benefits for a widening array of different kinds of medical care. There was no coordination, many incidental expenses fell "between the cracks," and there was no overall protection against catastrophic medical costs.

Consumers soon realized that these "basic" policies were inadequate for prolonged illnesses or expensive procedures. In 1949, the first "major medical" policy was offered as a supplement to the existing basic policies. Supplemental major medical policies provided protection against catastrophic medical expenses, picking up where basic policies left off. Typically there was a modest deductible, often some level of coinsurance, and a relatively high maximum benefit limit.

During the 1960s and 1970s, the industry moved towards offering "comprehensive" major medical policies, which covered most serious medical expenses, without any underlying "basic" plan. This provided for consistent, more easily understood benefits that did not make artificial distinctions between types of medical services or providers. Since that time, innovations have focused on efforts to improve the quality, coordination and cost-effectiveness of care, rather than on the fundamental structure of the coverage—a single, coordinated policy that handles a wide array of medical expenses on a consistent basis.

In many ways, Medicare reflects the times in which it was developed, resembling an old "basic" hospital/medical plan. Hospital and medical coverage are provided through separate programs, and benefit levels are closely tied to the type of service, type of provider and location of care. While this was not unusual when Medicare was first enacted, private insurers have found that there are a number of advantages to more coordinated programs.

For example, today many surgical procedures can be safely and effectively provided to Medicare beneficiaries as a Part A inpatient hospital procedure or as a part B ambulatory service. Medicare beneficiaries, however, face very different out-of-pocket costs depending on where the service is furnished. The resulting financial incentives may result in the beneficiary not receiving care in the appropriate setting, thereby adversely affecting quality of care. In contrast, private health insurance policies usually cover a comprehensive array of health care services, both in and out of a hospital, subject to a single, annual deductible.

This arrangement is easier for insured people to understand and more efficient to administer. Under this private sector approach, claims for services flow to a single responsible organization, and inquiries by insured individuals and their caregivers likewise can be made to one party. Among other things, this arrangement also facilitates disease management programs, through which insurers seek to apply the best practices to treatment of certain chronic diseases (e.g., asthma and diabetes mellitus), in order to control their progression.

DISEASE MANAGEMENT PROGRAMS

Disease management programs involve a wide variety of interventions to address patient needs in a timely and cost-effective way and support treatment by health care providers. These programs include patient education, patient monitoring, and the provision of specialized services. They are currently experiencing a period of tre-

mendous growth. The goal of these programs is to improve the quality of care and reduce costs by identifying patients with high risk conditions and contacting them and/or their physicians regarding compliance with best practice guidelines, patient non-compliance related to prescribed medications, tests ordered, and physician visits (e.g., physician use of beta blockers after a heart attack and patient taking medicine as prescribed). This concept aligns physicians and patients at the center of programs designed to reach all members of a disease population, not just the acutely ill. Some of the programs that have been developed include care management programs for asthma, heart disease, low-back pain and diabetes.

Disease management programs take a systematic approach to medicine that encourages patients to follow health-promoting behaviors, support a strong patient-doctor relationship and include all members of a chronic disease population. Such programs are designed by doctors and nurses, and focus on proven standards of care. They rely on practice guidelines developed by the medical professional societies and from other leading organizations such as the National Heart, Lung, and Blood Institute; the Agency for Healthcare Research and Quality; and recommendations of disease-based associations such as American Diabetes Association and the American Cancer Society. The programs provide education and supportive services for patients and respond to consumer demand for more personalized care. They provide physicians with information about practice patterns, identifying potential opportunities for improvements. Employers who have been supportive of these programs have seen improvement in employees' health status that can lead to higher productivity. Clinical and financial outcomes indicate improved quality of care, high levels of participant satisfaction, and reduced overall health care costs. In short, these programs not only enhance the quality of care and patients' quality of life, but they also help reduce the need for hospitalization, emergency department visits, and other costly services.

IMPROVING PROGRAM ADMINISTRATION

Some of the efficiencies achieved by the private sector are directly dependent on the consolidation of coverage under a single program—access to centralized records allows plans to more efficiently update and maintain beneficiary coverage and claims files and coordinate care. These efficiencies result in reductions in the costs of providing health care through such activities as utilization review (UR) and utilization management (UM) of health care claims. Both UR, to determine covered services, appropriate care, and establish fraud detection programs, and UM, to enhance efficiency and to improve and maintain quality of care, help link treatment options and health outcomes. This can only be carried out through links between all the various claims a beneficiary may have, which may be for a brief episode of care or for longer chronic disease states. This is particularly important for disease management programs mentioned above.

Sharing information about different types of services is extremely important for fraud detection programs. Both public and private health care systems have achieved substantial savings through their fraud detection activities. However, many health plans have established centralized anti-fraud detection units to accommodate different benefit plans and services. Centralized units can more efficiently service different benefits with specialized personnel and programs. Even more important than centralized units is access to centralized information made possible through information links between various data files for providers, claims, and covered persons and services. For example, links between services performed by different providers, such as hospitals and physicians, can be compared for appropriate diagnoses and dates of service. In this way a claim for a physician's hospital in-patient visit can be compared to the dates on which a patient was hospitalized, or a claim for laboratory work can be linked to the office visit at which the patient was seen and sent for tests.

A recent audit report by the Office of the Inspector General provides a good example of the hazards involved in having separate claims processing entities for Medicare Parts A and B. This report points out that Medicare has been paying twice for the same services—once to a skilled nursing facility (SNF) under the Medicare Part A prospective payment system and again to an outside supplier under Medicare Part B. Under current law, a SNF is reimbursed a prospective payment for covered services rendered to its Medicare beneficiaries in a Part A stay, and consolidated billing is required for all covered services. Outside providers and suppliers must bill the SNF (not Medicare Part B) for most services and supplies provided. The potential improper payments to Part B providers and suppliers totaled \$47.6 million in 1999, and occurred because edits had not been established to detect and prevent supplier claims noncompliant with the consolidated billing provision.

SIDESTEPPING MEDICARE'S STRUCTURAL PROBLEMS

Recognizing the constraints of its current structure, Medicare has, through the years, attempted to break down the barriers between its separate parts. HCFA has conducted various pilot projects under its general demonstration authority or based on specific Congressional mandates. For example, under one demonstration project, a single combined payment was made for both inpatient hospital services and certain physicians' services provided to Medicare patients undergoing a coronary artery bypass graft (CABG) in selected hospitals participating in the demonstration. An independent evaluation of this experiment found that it was quite successful, and that the combined payment provided the incentive for hospital personnel and physicians to work together to identify the most effective and efficient means to care for the affected patients. In other words, rather than have hospitals and physicians responding to the different and often conflicting incentives of separate hospital and physician payment systems, this demonstration provided a single payment to an integrated system of care.

Another example of Medicare experimentation is the On Lok/Program of All-Inclusive Care for the Elderly (PACE), under which monthly capitation payments from Medicare and Medicaid cover a comprehensive range of acute and long-term services provided to a very frail elderly population, all of whom are certified as needing nursing home level of care. In the PACE program, services are provided by a multi-disciplinary care management team, which includes all caregivers having contact with the patients, such as physicians, nurses, social workers, nutritionists, and physical and occupational therapists.

Both of these programs have been very successful, demonstrating the flexibility in the design of care management and payment programs that is characteristic of private insurance programs. But putting such programs in place requires special legislative or regulatory authority, in part because of Medicare's outmoded design.

THE PROMISE OF A COMBINED MEDICARE PROGRAM

The Medicare program is in need of substantial reform. Obviously, combining Medicare Parts A and B into a single program would not, by itself improve care coordination, disease management, and program administration and oversight. But, for many of these more substantial reforms to work effectively, a necessary first step is to eliminate the artificial and antiquated separation of the program into two parts as private insurers did many years ago. Thank you for providing me this opportunity to talk about Medicare reform from the perspective of the private health insurance sector. I would be happy to respond to any questions you might have.

Mr. BILIRAKIS. Thank you very much, Doctor.

Mr. Schulder, as soon as you get to the mike.

STATEMENT OF DANIEL J. SCHULDER

Mr. SCHULDER. Thank you very much. My name is Dan Schulder. I am the Legislative Director of the Alliance for Retired Americans, and on behalf of the Alliance, I thank you and all members of this committee for this opportunity to speak on Medicare changes and Medicare issues.

The Alliance, which was established on January 1 of this year, now has 2.6 million members across the Nation, retirees from affiliates of the AFL-CIO, community-based organizations and individual seniors have joined the Alliance to fight for social and economic justice and civil rights for all citizens.

As you know, Mr. Chairman, Medicare is one of society's great accomplishments. It has opened access to quality health services to both older persons and persons with disabilities from every income level.

Its pioneering role in restraining health care costs is one of its many unheralded successes. It has demonstrated that overhead costs can be kept low despite enormous volume and growing perplexity; and because of prudent management, the spending restraints of the Balanced Budget Act and revenues buoyed by the

economy over the last decade, there is no financial crisis facing the system for years to come.

At the same time, the Alliance and its members recognize systemic shortcomings in this system, including a lack of dental and vision care and routine preventive services such as checkups, limited nursing and home health care and mounting out-of-pocket costs. Seniors now spend \$1 in \$5 of their income for health care, and the older and poorer you get, the higher that proportion does go.

Medigap policies with drug coverage are becoming unaffordable and employer-based retiree health benefits are declining rapidly. Over the past decade, Medicare coverage, compared to what most workers receive under company plans, has declined. And in the coming decades, millions of baby boomers will line up for their entitlement to quality health care; and the Alliance is dedicated to making sure that that health care will be there for them.

In light of these needs and strengths, the Alliance stands for those who want to assure that Medicare will be modernized, expanded, receive adequate revenues and resources and will have the management capability to continue to deliver quality care to our citizens. There is no more important claim on the Nation's resources and energies over the coming years.

For the Alliance, our prime legislative objective this year is the enactment of a universal and comprehensive Medicare prescription drug benefit, standing alone or as part of other changes to the Medicare program. That is the first on the list of our members in the surveys that we have given to them.

You have asked us, in particular, to discuss the implications of merging Parts A and B in Medicare. There is no specific description in legislative proposals of exactly what such a merger might entail. A long history of separate trust funds, revenue streams, deductibles, cost-sharing differences, billings and contracting practices and solvency definitions all suggest there are no easy definitions of the desirability of such a merger. However, from the standpoint of beneficiaries, there are a number of questions that should be addressed.

Will such restructuring enhance or retard work on enacting a universal, comprehensive and defined pharmaceutical benefit?

What are the goals of restructuring?

If there are savings to restructuring, who benefits and who may lose?

Will restructuring help to establish an overall cap on out-of-pocket costs to beneficiaries?

Will the process enhance services to rural communities?

Will the States be inspired to enroll more QMB and SLMB eligibles?

Will preventive services be provided without deductibles and co-payments?

The Alliance believes that the central goal of modernization and restructuring activities must be the enhancement and expansion of quality services to beneficiaries and the overall strengthening of the Medicare system working in their behalf. If the goals, however, include covert attempts to cap annual expenditures, end the entitlement status of Medicare, create voucher systems and construct

a multitiered system of health services, the Alliance will oppose them. It all depends, after all, on mechanics and motives.

It is also a question of priorities, Mr. Chairman. The need for a prescription drug benefit presents a crisis for millions of Americans today. The escalating costs of drugs has created Medigap policies with premiums reaching \$9,000 in annual costs for 75-year-old women in some States.

Mr. Chairman, more than a million beneficiaries have lost HMO coverage and there are more to come. Medicare pays for a declining portion of health care costs and there is no limit on liability.

The Alliance does believe that there are certain aspects of Medicare administration that should be addressed. The first issue is the adequacy of HCFA administrative resources. HCFA should examine better ways of contracting for services, create bundled payments for some services and use competition to select intermediaries and carriers. It should assess the benefits of creating a primary care case management system to better guide treatment in fee-for-service programs and look again at offering disease management services to enrollees, which could improve care while reducing costs.

We also would call for an increase in SHIP programs, State health insurance programs. For a small investment, lots of people could get more information for more efficient use of the system. We would like to see less paperwork and more consumer education. We support these kinds of modernization directions because they are both good for the beneficiaries and the system.

There is no question, Mr. Chairman, that the Medicare program will need greater resources even if every acceptable efficiency and cost-saving change is incorporated. A drug benefit will be expensive, as would an overall stop-loss cap. Millions of new persons will become eligible in a few years. That is why the Alliance supports the use of on-budget surplus funds to strengthen Medicare and extend solvency. We hope that the 2001 tax changes will not prevent such an allocation, and if so, we would expect the Congress to revisit its actions on taxes and reassess national priorities. We also foresee a review of the adequacy of current payroll taxes to support expanded benefits and increased numbers of beneficiaries.

The Alliance does support your efforts, Mr. Chairman, to explore ways to assure a more efficient and effective Medicare program, and we trust that you agree with us and with millions of seniors, their families and the health care workers treating them that the focus of Medicare improvements in the short and the long term must be the guarantee of first-class care for all Medicare beneficiaries. And on that basis, you can count on us and our members to work with you and then with this committee.

Thank you.

[The prepared statement of Daniel J. Schulder follows:]

PREPARED STATEMENT OF DANIEL J. SCHULDER, ASSISTANT DIRECTOR, DEPARTMENT OF GOVERNMENT AFFAIRS, ALLIANCE FOR RETIRED AMERICANS

On behalf of the Alliance for Retired Americans, its officers and members, I thank you Mr. Chairman for the opportunity to present testimony today on Medicare reform and modernization issues including the merging of Medicare Parts A and B.

The Alliance, which was established on January 1 of this year, now has 2.6 million members across the nation. Retirees from affiliates of the AFL-CIO, community-

based organizations and individual seniors have joined the Alliance to fight for social and economic justice and civil rights for all Americans. We believe that all older and retired persons have responsibility to strive to create a society which incorporates these goals and rights.

As you know, Mr. Chairman, Medicare is one of this society's great accomplishments. It has opened access to quality health services to both older persons and persons with severe disabilities from every income level. Its pioneering role in restraining health care costs is one of its many unheralded successes. It has demonstrated that overhead costs can be kept low despite enormous volume and growing complexity. And, because of prudent management, the spending restraints of the Balanced Budget Act and revenues buoyed by the economy of the last decade, there is no financial crisis facing the system for years to come.

At the same time, the Alliance and its members recognize systemic shortcomings including a lack of dental and vision care, routine preventive care such as check-ups, limited nursing and home-health care and mounting out-of-pocket costs. Seniors now spend one in five dollars of their income for health care and the older and the poorer you get, the higher that proportion grows. Medigap policies with drug coverage are becoming unaffordable and employer-provided retiree health benefits are declining rapidly. Over the past decades, Medicare coverage compared to what most workers have under company plans—has declined. And, in the coming decades, the millions of baby boomers will line up for their entitlement to quality health care. The Alliance is dedicated to making sure that Medicare will be there for them and for all of our children and grandchildren.

In the light of these needs and strengths, the Alliance stands with those who want to assure that Medicare will be modernized, expanded, receive adequate revenues and resources and will have the management capacity to continue to deliver quality care to our citizens. There is no more important claim on the nation's resources and energies over the coming years.

The Alliance's prime legislative objective this year is the enactment of a universal and comprehensive Medicare prescription drug benefit standing alone or as part of any changes to the Medicare program. Of all improvements to Medicare, this benefit is first on the list of Medicare improvements in surveys of our members.

You have asked us, in particular, to discuss the implications of merging Parts A and B of Medicare. There is no specific description in legislative proposals of exactly what such a merger might entail. What we understand is that the long history of separate trust funds, revenue streams, deductibles, cost-sharing differences, billing and contracting practices and solvency definitions all suggest no easy definitions of the desirability of such a merger. However, from the standpoint of beneficiaries, a number of questions should be addressed:

- Will such restructuring enhance or retard work on enacting a universal, comprehensive and defined pharmaceutical benefit?
- What are the goals of restructuring?
- If there are savings to restructuring, who benefits, who loses?
- Will such restructuring help to establish a overall cap on out-of-pocket costs to beneficiaries?
- Will the process enhance services to rural communities; will the states be inspired to enroll more QMB and SLMB eligibles; will preventive services be provided without deductibles and copayments?

The Alliance believes that the central goal of all modernization and restructuring activities must be the enhancement and expansion of quality services to beneficiaries and the overall strengthening of the Medicare system working in their behalf. If the goals, however, include covert attempts to cap annual expenditures, end the entitlement status of Medicare, create voucher systems and construct a multi-tiered system of health services, the Alliance will oppose them. It all depends on both mechanics and motives.

It is also a question of priorities, Mr. Chairman. The need for a prescription drug benefit presents a crisis for millions of Americans. The escalating price of drugs has created Medigap policies with premiums reaching \$9,000 in annual costs for 75-year-old women in some states. Mr. Chairman, more than a million beneficiaries have lost Medicare HMO coverage and there are more to come. Medicare pays for a declining portion of health care costs and there is no limit on liability.

The Alliance does believe that there are aspects of Medicare administration that should be addressed. HCFA should examine better ways of contracting for services, create bundled payments for some services and use competition to select intermediaries and carriers. It should assess the benefits of creating a primary care case management system to better guide treatment in fee-for-service programs and look again at offering disease management services to enrollees which could improve care

while reducing costs. We support such modernization directions because they can be good for both beneficiaries and the system.

Mr. Chairman, there is no question that the Medicare program will need greater resources even if every acceptable efficiency and cost saving change is incorporated. A drug benefit will be expensive as would an overall stop-loss cap. Millions of persons will become eligible in a few years. That is why the Alliance supports the use of on-budget surplus funds to strengthen Medicare and extend solvency. We hope that the 2001 tax changes will not prevent such an allocation and if so, we would expect the Congress to revisit its action on taxes and reassess national priorities. We also foresee a review of the adequacy of current payroll taxes to support expanded benefits and increased numbers of beneficiaries.

The Alliance does support your efforts, Mr. Chairman, to explore ways to assure a more efficient and effective Medicare program. And we trust that you agree with us and with millions of seniors, their families, and the health care workers treating them, that the focus of Medicare improvements, in the short and long term, must be the guarantee of first-class care for all Medicare beneficiaries. On that basis, you can count on us and our members to work with you and with this Committee.

Thank you.

Mr. BILIRAKIS. Thank you very much Mr. Schulder.

You know, on the point of contractors, we are told by HCFA that the way the legislation now occurs, they really don't have the flexibility to be able to choose the proper contractor; or even if a contractor doesn't function as they well as they should, to be able to make changes and that sort of thing. It is something that we are looking at when we are talking in general in connection with the prescription drugs portion of modernization, as we call it, of HCFA. We, of course, think in terms of that as well as some of these other things. I just wanted you to know that.

Mr. SCHULDER. Just giving me the authority to use the best contractors. Thank you.

Mr. BILIRAKIS. Ms. Moon, please proceed.

STATEMENT OF MARILYN MOON

Ms. MOON. Thank you for the opportunity to be here, Mr. Chairman, Mr. Brown and other members of the committee.

My perspective on Medicare comes from more than 20 years researching this program, serving from 1995 through 2000 as a member of the public trustees of the Board of Medicare Trust Funds, and a long interest in beneficiary concerns in which now I have been working to considerable degree with the Medicare Rights Center in New York which counsels beneficiaries and discusses with them a number of their concerns.

I believe, overall, that combining Parts A and B of Medicare would at best make only minor contributions to improvements needed in the program. In fact, it is possible that too much attention on such a combination will deflect attention from other important issues that need to be discussed. Consider the four goals that are mentioned in this today, about combining A and B, and I think that those are goals in general that are laudable goals to achieve, but go well beyond the A and B Trust Fund issue.

No. 1, simplifying the program: Medicare beneficiaries are often confused about the Medicare program and Parts A and B, and HI and SMI sound confusing; but the needs go beyond understanding the two parts. The need is really for beneficiaries to have a single point of entry into the system where they can call and get information—get help, that is—from people who are well informed about the program, who answer the phone and who provide the kinds of

information and support that such beneficiaries need. This requires resources and a commitment to a single point of entry, and it doesn't really matter how many different complicated parts there are in the system as long as the individual sees that nice single point of entry.

Improving cost-sharing: This is an area that people have talked about a lot and is of particular interest to me. The combination of deductibles and coinsurance for Medicare certainly does represent an ad hoc selection of things that were done for strange historical reasons, and it would be very nice to improve the cost-sharing structure of this program for a number of purposes. But combining A and B offers relatively few advantages for addressing these issues. It would make it easier, for example, to create a combined deductible, but that is hardly the problem with the benefit structure that we currently have.

Moreover, many private insurance plans continue to have multiple deductibles. My own plan has two deductibles, and one that is different whether I am in or out of the preferred providers, as well as a hospital deductible; and when I look at the FEHBP, I see that some of them have six deductibles, and they also have a deductible for prescription drugs, depending on whether you are in or out of the PPO.

The problems with the cost-sharing structure, though, deal much more with, for example, issues of the high coinsurance that beneficiaries who have been in the hospital for a long period of time have to pay, disadvantaging sicker beneficiaries, and as Bill Scanlon pointed out, deductibles and coinsurance that do little to affect use because use is not discretionary for those individuals. So balancing that, the two different deductibles, might make good sense. But more important would be to make sure that the cost sharing does not put sicker beneficiaries at an enormous disadvantage.

One of the concerns I have, for example, with home health copays is when we subject them to—for individuals who largely are very sick for other reasons, they place an enormous burden on the sickest of beneficiaries. Putting the home health under Part B of the program, for example, was a good compromise that effectively raised the premium on Part B and was asking people that get home health to pay something more.

As other people have mentioned, catastrophic coverage would also be particularly helpful.

The third goal I think of achieving greater efficiency in program management and coordination has also been discussed to some point. Again, providers probably deserve a single point of entry into the system and careful coordination. An A-B merger probably makes some sense in terms of doing the kinds of coordination of care that Dr. Young spoke about, but again the most important thing is to have the data and have one agency in charge of both parts of the program, which means that you need, again, additional resources to make data more timely, to try to do the kinds of care coordination that I think many people believe is important.

Again, it is more a matter of resources than combinations.

And finally, Medicare and financing issues are another area of particular attention for people who talk about an A-B contribution. As others have expressed on this panel, I am concerned about mak-

ing financing decisions on the basis of a technical adjustment. The financing decisions are going to be tough ones. I think there are going to need to be new revenues put into this program, but that deserves a careful discussion of what is the right balance of payroll tax burdens on individuals who are in the program and general revenues, rather than setting up any kind of formula establishment.

Part A and Part B actually do grow together, even though Part B has grown faster than A over time; and that is largely because of the shifting out of services from Part A in hospital care to outpatient services. That is a success of the program that it has actually been flexible enough to handle that change. It has not been flexible enough to handle the change of the greater reliance on prescription drugs because those have never been covered by the program. But—the Part B part of the program I don't believe is as troubled, but it certainly needs to be part of the financing discussion.

As Bill Scanlon also mentioned, Parts A and B are listed in the Trustee's reports every year as a share of GDP. That is a good place to start. Perhaps some more attention to that, in understanding the implications, would help; but I think, again, that can be done without necessarily combining the two parts of the program.

Thank you.

[The prepared statement of Marilyn Moon follows:]

PREPARED STATEMENT OF MARILYN MOON, THE URBAN INSTITUTE

Mr. Chairman and members of the Committee: I appreciate the opportunity to be here today to testify on issues of combining Parts A and B of Medicare. As you are well aware, there are many different reasons why people have advocated such a combination over the years. In my testimony, I examine a number of the goals that people have expressed, consider whether it is necessary to combine Parts A and B to achieve those goals, and suggest other remedies that are also important to consider for modernizing Medicare. I conclude with several cautions about problems that such a combination could create.

A BRIEF LOOK AT THE MEDICARE PROGRAM

It is instructive to look briefly at the history of Medicare and consider why there are two parts of the program. Until very late in the legislative process, only Medicare Part A was under consideration. In the private sector, many people who had health insurance had it only for hospitalization. As the most expensive part of health care, it was considered the highest priority for an initial insurance program for the elderly. Thus, the separation occurred in part because of the last minute inclusion of Part B. In addition, by making this a voluntary program and requiring beneficiary premiums, it was thought to be more acceptable to physicians leery of participating in a government program. It appeared to be more like insurance and indeed was established with rules for a "hands off" approach to the practice of medicine.

Ironically, in the beginning, the Part A deductible of \$40 was less than the \$50 deductible for Part B. But Part A was indexed to the growth in hospital spending while Part B has only been subject to two discreet increases. Today at \$792, the Part A deductible is much higher than the \$100 Part B deductible, even though many advocates of cost sharing would likely propose that the Part B deductible be the higher one. While many observers of Medicare have appropriately suggested that the benefit package is outmoded and inadequate, those criticisms are directed more at the lack of upper bound protections and prescription drug coverage in the basic package of benefits that Medicare covers.

Medicare has always relied upon private entities to process claims and perform other insurance functions. Intermediaries serve Part A of Medicare, while Part B uses Carriers. But even beyond the titles, there are many aspects of Medicare con-

tracting that can and should be considered in reform. But it is not just the A/B distinction that matters; restrictive rules on who can have these contracts, prohibitions against profits, and limitations on the Health Care Financing Administration's ability to seek improvements in performance are also major issues.

Although Part B of Medicare is voluntary, nearly all those eligible pay the premium and participate in the program. The subsidy makes this coverage a good deal for the elderly and disabled. Four groups make up most of those who choose not to participate: those with very low incomes who cannot afford the Premium (and who do not get help from Medicaid or related programs), those just coming on to Medicare who have not yet enrolled, federal retirees who enroll in an HMO under FEHBP, and those whose current employer (or spouse's employer) provide health insurance that is primary to Medicare. This latter group almost always fares better by relying on that private insurance for Part B-type services. And because their enrollment in the private sector saves money for the program, these individuals are not required to pay a penalty to enroll in Part B when they give up that private insurance.

THE GOALS

Combining Parts A and B of the program has often been suggested as part of other reforms, at least implicitly suggesting that much of the confusion and complexity is due to this particular split. Further, even larger goals—such as financing of Medicare—have also been linked to the importance of making such a change.

Four of the important goals mentioned are:

- Simplifying the program;
- Improving cost sharing and making it more rationale for beneficiaries;
- Achieving greater efficiency in the management of the program;
- Treating the Medicare program as a whole in considering financing issues.

These are laudable goals and need to be part of reforms that seek to make Medicare work better for beneficiaries, providers and taxpayers. But in many ways they go well beyond what can be achieved with combining A and B. Indeed, there is a danger in seeing that change as a major contribution and ignoring other key issues necessary to meet these goals.

Simplifying the program. Medicare beneficiaries are often confused about the Medicare program. They do not focus on the split between A and B; indeed, the terminology is confusing. But since most of them are in both parts of the program, this is not particularly a problem in and of itself. Further, the new Medicare+Choice option added a confusing Part C to Medicare.

Confusion arising about contacting intermediaries or carriers might be reduced with a A/B merger. However, problems for beneficiaries in getting help for the Medicare program goes well beyond confusion over who to contact. A modern, consumer-friendly program needs substantial resources and a commitment to simplifying customer service from the perspective of the consumer. Even a very complicated program can establish a single point of contact with well-informed workers helping Medicare beneficiaries with problems. If that is the real goal, the A/B issue essentially becomes irrelevant. Instead, it is the resources and commitment to improvement that need to go into the development of such a framework that matter.

Improving Cost Sharing. The purpose of cost sharing is presumably to make the user of health services more aware of costs and to discourage unnecessary use. For persons with employer-provided insurance this usually means an initial, modest deductible (or sometimes two) and then limited copays, usually for specific services. For example, some plans have high coinsurance for non-emergency use of hospital emergency rooms. Almost all have an upper bound on what their enrollees must pay out of pocket (called a "stop loss"). These cost sharing conventions have changed and evolved over time, but Medicare has retained essentially the same structure since 1965.

The combination of deductibles and coinsurance for Medicare represents an ad hoc collection of payments with little defensible justification as points of control for the use of health care services. As mentioned above, cost sharing under Medicare is essentially a historical artifact. And since its inception, little careful attention has been devoted to updating it to reflect cost sharing structures found in other health plans. It is not the fact that there are two deductibles that makes Medicare unusual, but rather that the Part A deductible is so much larger than that for Part B. Elsewhere, insurers often recognize that physician services tend to be more subject to discretion than hospital care and hence establish a higher deductible for physician services.

Another way in which cost sharing is unusual in Medicare is the linkage of the hospital deductible and coinsurance to a "spell of illness" and imposition of the coin-

surance only after 60 days. This sets cost sharing highest for those who are sickest. The same problem arises with skilled nursing facility coinsurance. In addition, totally missing from Medicare is any upper bound limit on cost-sharing liabilities. Most private plans offer such "stop loss" protection so that once patients have spent a certain amount out of pocket, they no longer have to continue paying cost sharing. But Medicare has no such provision. Beneficiaries with complicated illnesses (and no Medigap protection) can end up owing tens of thousands of dollars towards the costs of Medicare covered services. This is particularly the case under Part B of the program where the 20 percent coinsurance can become quite large for those with extensive medical bills. Part B cost sharing constitutes about two-thirds of all Medicare cost sharing liabilities.

But combining A and B offers relatively few advantages for addressing these issues. It would make it easier, for example, to create a combined deductible. But that is not the main problem and in fact, many private insurance plans also have two deductibles. Moreover, that approach is problematic: To get a combined deductible that raises the same amount of contribution from beneficiaries would require a deductible of about \$400. For those who are hospitalized in a given year, this would lower their cost sharing liability. But for the nearly 80 percent who do not go into the hospital, they would only see a rise in the deductible from \$100 to \$400. Such a large increase could be very unpopular with beneficiaries.

A better approach would be to lower the Part A deductible and eliminate both the spell of illness concept and the coinsurance for hospital stays. A relatively modest increase in the Part B deductible could offset much of those costs. Another important need is for a general upper bound on cost sharing, allowing at least some beneficiaries to forego purchasing private supplemental insurance.

Finally, one impact of a combined A/B Medicare program might reduce costs to beneficiaries. That is, if the Part B premium were to become a combined premium and linked as the Part B premium is now to the growth in costs of the benefits, the new premium would grow more slowly than under current law. This is because Part B is expected to grow more rapidly than Part A over time. For example, the Part B premium is expected to rise over time to about 11 percent of total Medicare spending, up from about 9 percent at present.

Making Medicare's cost sharing structure more rational and protecting those with the highest costs are important goals for Medicare reform. But it makes most sense to do this in the context of a broad range of changes rather than focusing just on a combined deductible.

Achieving Greater Efficiency in Program Management and Coordination. One need not look very far to find critics of the Health Care Financing Administration and its management of Medicare. But the greatest problem here is lack of resources. Medicare's administrative costs of less than 2 percent are so low that any entity seeking to manage the program would be severely constrained. Even efficient private sector plans require a budget of three times that level—or more—in order to effectively oversee the complicated world of insurance. Only when there are sufficient resources will management improvements be possible. A considerable amount of flexibility and authority needs to be given to the management team to allow them to improve service both for beneficiaries and for providers of care.

Contractor reform is an essential piece of the changes that need to be made in Medicare. Medicare needs to contract with companies that are most skilled at claims processing, medical review and data collection and management. This may require a number of different contractors; consolidation is less important than competence and accountability. Again, a well managed organization can tolerate having a number of different entities as long as the lines of responsibility are clear and those contracted to do the job are skilled. The current system is a long way from there, but not because of carriers versus intermediaries. Rather the problem is that the government allows Blue Cross to nominate the intermediaries, restricts what HCFA can do in controlling these intermediaries, limits what types of organizations can contract to provide services both as carriers and intermediaries, and disallows contracts allowing for profits (hence excluding a number of potential participants). Efforts to achieve greater efficiency need to focus on these issues first, and the A/B split is only a small part of that issue.

Another important need for a well-functioning Medicare program is good coordination across different types of care for those who are still in traditional Medicare. Fee-for-service arrangements are inherently weak in providing incentives for coordination, but the track record of many HMOs where such coordination is supposed to be central leaves much to be desired as well. Consequently, the oversight of Medicare needs to focus on developing creative ways to bring coordination into the traditional program. This might be through disease management or case management models, for example. In those cases, a combined A/B structure makes sense, al-

though this could be achieved via a de facto approach as well. That is, good data combining patient level information so that high cost cases can be identified and tracked can be done without a formal merger of the two parts of Medicare. HCFA already produces such data files, although more needs to be done in a timely way.

Medicare and Financing Issues. Critics of the current organization of Medicare often point out that much of the focus of attention is on Part A of the program. Its trust fund provides insights into the balance between the dedicated revenues from payroll taxes and elsewhere and spending on Part A services. That trust fund thus serves as an early warning signal of problems ahead and as a reminder that taxpayers have contributed over time more than enough to meet the needs of Part A. In the future, when Part A needs to draw on the trust fund balance to pay benefits, it will essentially be calling on the resources made available earlier. Any combination of A and B should keep these advantages.

The biggest danger with a combined approach is that a technical adjustment may be used as a back door means for dramatically changing the financing of the program. Both Parts A and B of Medicare need to be part of any consideration of financing issues. But formally combining A and B raises a number of complicated issues about how to view the financing of the program and how to think meaningfully about a trust fund structure. Financing issues are much broader than an A/B combination discussion; that discussion is essential to Medicare's future but ought to look broadly at where the resources should come from to support this important program.

The Bush Administration's efforts in this regard offer a troubling example of casually combining A and B. That is, the initial budget blueprint document submitted by the Administration treated Part B as if it were in deficit because it relies on general revenue financing. That is, it examined both A and B spending, but only part of the financing of the program when looking at Medicare's financial status. General revenues have been a major funding source for Medicare since its passage in 1965 and that obligation is spelled out in statute. It makes no sense to treat Part B as in "deficit" and thereby imply that payroll taxes should support both Parts A and B. This is implicitly scaling back the funding for Medicare below its current level. Such an argument makes no more sense than assuming that spending on Medicaid, Veteran's benefits or even defense should be covered by the Part A Trust Fund. All of these other sources of spending have no more legal claim on general revenues than does Part B.

Part of the case made in the Bush document for combining A and B in examining Medicare was a criticism of the shift of some home health benefits from Part A to Part B in the Balanced Budget Act of 1997. This change, which returned home health closer to how it was treated in 1966, did make Part A look better and to that extent it could also be misinterpreted as improving financing. But it is incorrect to argue that it "had no economic consequences." By shifting a majority of home health care to Part B, beneficiaries costs rise since their Part B premium is 25 percent of the costs of Part B services. Thus, this was an indirect, but intended, increase in beneficiary contributions. In fact, beneficiaries' share of combined A and B spending will rise from about 9 percent prior to the BBA to nearly 11 percent when the phase in of home health is completed in 2004. Over the ten year period, that translates into a per capita premium increase of nearly \$1200. Most beneficiaries would not consider this a meaningless change; indeed they would likely welcome having home health returned to Part A.

Another claim that is often made about Medicare is that the growth in Part B, which has historically been higher than that for Part A, reflects problems with health care spending in Medicare. The growth over time between the two parts, however, represents a natural shift that has been occurring in health care for everyone. Surgery is more often done on an outpatient than an inpatient basis today, for example. More procedures are undertaken in physicians' offices. The improvements in health care delivery that have allowed such changes reflect improvements that speed recovery and enhance the quality of life of beneficiaries. Without such a shift, Part A spending would have had to be much higher than it is today. Part B growth, thus, does not represent a failure in health care.

Both parts of Medicare should be considered with regard both to their spending and sources of income. In the Trustees' report each year, information on the combined share of GDP that Parts A and B are projected to need over time are provided. This is a reasonable starting place to examine the combined impact, although it understates Medicare's possible financing by showing costs on a pay-as-you-go basis. This allows no ability to build a reserve to smooth the impacts of the Baby Boomers' retirement or other demands, for example, as is the intent of the trust fund for Part A.

Should there be limits or constraints on general revenue contributions to Medicare? Even those who have implicitly argued for such a limit usually do not propose reducing general revenue contributions to zero. In a recent article, colleagues and I created an artificial trust fund for Parts A and B in which we examined the effects of one potential limit for general revenues. We assumed that the GDP share of general revenue going to Part B would remain constant. That provides one way to look at both A and B in a combined framework, again with no formal combination of the two. Interestingly, that approach indicated that, using the 2000 Trustees' report numbers, the date of exhaustion of the trust fund moves earlier by five years, but still well into the future. But even this analysis can miss the point: Medicare will need additional resources over the future to handle a doubling of the population served and a near doubling of the share of the U.S. population served by this program. Efficiency improvements and other changes in Medicare can help, but will not be sufficient to pay for another 36 million participants.

Both Parts A and B will need support. More willingness to raise revenues is needed to assure Medicare's future. And a direct discussion of how the shares should be broken out among payroll taxes, general revenues and beneficiary premiums needs to get underway. For example, it may be reasonable to obtain a disproportionate share of additional dollars from general revenues, which require people of all ages to pay and in a progressive manner.

PROBLEMS WITH COMBINING A AND B

One of the chief concerns with combining Parts A and B of the program is how to treat those who enroll only in Part A and not B. When beneficiaries do so because they prefer their HMOs (in the case of FEHBP enrollees) or because they are still working, the federal government saves money by their choice to decline or defer the Part B subsidy. Special attention would need to be placed on how to treat these beneficiaries. As the number of older workers increase over time, this may become even more of an issue.

The other major problem has already been mentioned and that is the potential for effectively decreasing the funding for Medicare if proper attention to a stable base of support for Part B is not addressed in such a combination. Financing decision should not implicitly be made via technical adjustments.

In sum, Medicare's concerns go well beyond the issue of a program with multiple parts; the real concern needs to be ensuring that those parts are well coordinated, however organized, that resources are devoted to improving the way the program interacts with both beneficiaries and providers of care, and that the program is sufficiently financed to cover the care essential to this beneficiary population.

Mr. BILIRAKIS. Thank you, Ms. Moon.

Ms. Means, please proceed.

STATEMENT OF KATHLEEN E. MEANS

Ms. MEANS. Thank you, Mr. Chairman and Mr. Brown and other members of the subcommittee, for inviting me to testify today.

I did want to mention to the members that I have worked in Medicare for 32 years now. I started working in 1969 in The Bureau of Health Insurance, just a few years after Medicare was enacted; and so I have seen enormous changes in the design and evolution of the program. I also bring to this discussion some private sector experience, having worked as Director of Health Benefits in Chicago for the national Blue Cross and Blue Shield Association.

One of the first things I would like to say to you as a subcommittee is that I think using the terminology merging of Part A and Part B is quite misleading. I am not here to talk about merging Part A and Part B. I am here to talk about good benefit design for both A and B benefits. And the kind of ideas that I would like to offer up to you do not require joining the financing or changing the underlying structure, the financing structure of the program.

I think it is important in the context of adding an outpatient prescription drug benefit, of which I am a strong proponent, that it is

equally important to modernize the Part A and Part B benefits together with doing the drug benefit.

I think it is important to consider improving protection against catastrophic cost, especially on the hospital side.

I think it is important to improve efficiencies for incentives in economy overall in the program, and that includes, particularly, attention to Part B.

I also think it is important to minimize dislocation for beneficiaries entering the program and coming off of private health insurance policies, as they age into the program or as they enter through disability. There are very significant differences between what has become typical in the private insurance market, particularly through employer group health plans and the Medicare benefit design we have today.

Although this is outside of the scope of this testimony, I do support improving the business model for the Medicare+Choice program and I think one building block toward doing that is to establish a better benefit foundation for the Medicare+Choice program. And you can do that both by adding a drug benefit and by making some modernization to Part A and Part B.

And I would like to put a practical reason on the table for members as to why it might be useful to do some of these Part A and Part B changes. That is that it actually contributes—potentially contributes financing that you could capture to offset the cost of adding the drug benefit. The resulting package, A-B reforms plus a drug benefit, would be much richer in actuarial value than the current law package, and the changes I would like to speak to you about on the cost-sharing side would be much less so than the increased value of the benefits.

I am not going to spend the time identifying the deficiencies because I think the other witnesses have done that very well with respect to Part A and Part B. So I would like to immediately draw your attention, if I could, to a chart that I included in the written testimony—it is on page 8—and to share with you the details of a proposal that was put forward last year in the Senate Finance Committee that generated a great deal of bipartisan interest. That's not to say that every member of the Finance Committee supported it; that is certainly not the case. I would have considered it a miracle had it been the case. But I would like you to see some of the ideas that were considered on the Senate side and that are being actively considered by some in this session as well. And I recognize now, listening to some of this discussion, some of our own language might be a little bit misleading, but I will just hit some of the highlights.

What you will see is the proposal exactly as it was considered last year in the committee. So it is describing key Medicare benefits in the year 2000. To the right are some of the proposals that we put in front of the members of the committee.

Basically, it recommended combining the deductible for Part A and Part B. That does not mean you are literally combining with the deductible, but if you come up with a common deductible—we propose \$500—you are in effect reducing the Part A hospital deductible, you are raising Part B. This does not have to happen all

at once. These kinds of changes could occur over, say, a 3-to-5-year phase-in period to meet in the middle.

There are a lot of good reasons for doing that. I have elaborated on them in the written testimony.

One of the things that we proposed, that a lot of the members supported, was going back and restoring some of the changes that members had supported in 1988 as part of the Medicare Catastrophic Act. That was primarily to enhance the hospital benefits, no separate inpatient deductible, eliminate the spell-of-illness concept.

I don't recall whether any of the members, witnesses here have mentioned that. Under the spell-of-illness concept, some small numbers of beneficiaries can be hospitalized multiple times during the year, depending on where their admissions occur. They can experience multiple inpatient deductibles; if you had three, you could experience basically \$2,400 in outpatient cost for that reason alone.

In addition, we also recommend just going to straight 365 days of covered inpatient care. This is, in fact, typical of private insurance and it affects a very small number of people, but it's very valuable insurance protection to people who are catastrophically sick.

We also proposed modified cost sharing on certain Part B benefits that have no cost sharing today. That basically was to reflect the principle that there is no benefit in the package that ought to be entirely a free good to beneficiaries, and—however, we were sensitive to some of the issues that I think Dr. Moon just referred to.

For instance, on the home health, we did not propose going to a straight Part B 20 percent coinsurance rate. Instead, we proposed a modest \$5-per-visit cap at \$100 per year.

So there are various options that you could consider to structure modest levels of cost sharing for beneficiaries that I think most people would find reasonable in today's setting.

As I understand current law, any selected—any preventive benefits would not be subject to these deductibles; and in the Finance Committee proposal, we recognize that some of the ideas changed cost-sharing relationships and slightly increased obligations for all beneficiaries, on average. That meant that we also restructured the low-income subsidies to make sure that low-income beneficiaries maintained their protection and access to benefits.

I just wanted to emphasize that these kinds of changes do not require merging of the underlying health insurance and supplementary medical insurance trust funds or any change in the sources of revenues to those trust funds.

I would like to address the question of how this could benefit you in the larger prescription drug debate. In the Senate Finance Committee draft proposal that we examined last year, these changes were paired with a fairly comprehensive prescription drug benefit.

For reasons that I will be pleased to explain, these kinds of changes offer potentially offsetting savings, depending on how you structure the changes and recognizing that the baseline has changed and that some of CBO's scoring procedures have changed and certain assumptions about things have changed this year.

I think there is still an opportunity to explore some of the practical legislative scoring benefits of doing these things together; and just to give you an example, last year we did a comprehensive drug

benefit with a \$250 deductible, declining cost sharing with a full continuum of drug coverage—no hole, so to speak, or donut in the coverage. We tested the premium of an additional drug premium of \$40 per month. We paired that with these Part A and Part B changes. That drug benefit scored at \$240 billion over 10 years.

The kinds of Part A and Part B changes that you see detailed on the chart resulted in about \$70 billion in net savings, reducing the cost of the drug benefit to \$170 billion. So as you are looking for ways to finance the benefit and also achieve other important program goals, you might want to consider these kinds of modifications to the overall package.

And finally, Mr. Chairman, I would like to close by introducing one more concept. It goes a little bit beyond the discussion of just modifying Part A and Part B benefits, but it is an idea that I have not heard openly discussed on the House side, but which is being discussed by some on the Senate side. And that is—it is the concept of a replacement plan strategy for accomplishing all of the reforms that members would like to accomplish in Medicare over the next decade.

This concept is well understood in private health insurance. It is basically a technique that employers follow in large group health plans when they want to introduce a new benefit package to employees and they already have a long-existing plan that employees are enrolled in. What they basically do is offer a second comprehensive benefit package to their employees in the expectation that over time the new package will gradually replace the old package.

This has one major advantage. It does not require any beneficiary to change or lose the coverage that they currently have in the current law package, if it is working for them. This replacement plan concept allows you to—allows people to enroll and accept the new benefits and the new changes in a different framework and allows the other program to be phased out for as long a period of time as members would like to do politically. It could literally be phased out over a 30-year period if that was your preference.

Adapted to Medicare, this replacement plan strategy would bundle all of the reforms that you would propose to accomplish into the new plan. One other major advantage of doing this is that it minimizes disruption to the Medigap market. I heard several of the members in their opening statements express concern about what changes to A-B benefits might mean for the supplemental market.

If you pursue the replacement plan approach, you could leave the Medigap market essentially intact for those beneficiaries that remain in the current law package. For those beneficiaries who choose to enroll in the new package, you would create new Medigap offerings designed around that particular benefit plan. And I think that is a significant advantage for members to think about.

The analogy that we used in discussing this on the Finance Committee last year was the very program that a lot of Federal employees are familiar with, but it was the introduction of the FERS pension plan compared to the Civil Service Retirement System. For those of us who were working in the Civil Service Retirement System in 1983, we remember well when our pension plan was going to be changed.

If you think Medicare beneficiaries care about their health insurance, I can tell you Federal employees care equally strongly about their pension benefits. And so it is a very major change to introduce to people with long-term ramifications for their economic security. It was done in a very methodical way with a very intensive education campaign, and people were given the choice of which system to stay in for the future.

I would just mention from former Chairman Bill Roth's standpoint on the Finance Committee, he had worked on Government Affairs, he had seen a very successful transition of FERS in lieu of the Civil Service Retirement System and felt that was a very interesting model for members to consider with respect to Medicare.

I want to thank you, Mr. Chairman, for this opportunity to testify. I will be happy to answer any questions. Thank you.

[The prepared statement of Kathleen E. Means follows:]

PREPARED STATEMENT OF KATHLEEN E. MEANS, SENIOR PUBLIC POLICY ADVISOR,
PATTON BOGGS, LLP

INTRODUCTION

Mr. Chairman, thank you for the opportunity to appear before the Committee today to discuss my views on the modernization of the Medicare program, with special attention to the current law benefits under Part A and Part B of Medicare. In the context of the larger public debate over Medicare reform, including the addition of an outpatient prescription drug benefit, fresh attention has been focused on the current law package, independently of expanding coverage for drugs. In my view, the current law package needs to be modernized for reasons I will describe below.

By way of background, immediately prior to joining Patton Boggs, I directed the healthcare staff for the Chairman of the Senate Finance Committee in the 105th and 106th sessions of the Congress. I have also served on the majority staff for the Health Subcommittee on Ways and Means and in the Senior Executive Service in the Health Care Financing Administration (HCFA). My private sector experience includes working for the Healthcare Leadership Council, as a Director of Health Benefits in the Blue Cross and Blue Shield system, and in private consulting. The testimony is organized to discuss the following matters:

1. Broader reform context for Medicare benefits modernization
2. Identification of major Parts A and B benefit design problems
3. Review of a comprehensive set of draft policies proposed last year by the former Chairman of the Senate Finance Committee
4. Major fiscal and other implications of modernizing Medicare benefits

Section I. Broader Reform Context for Medicare Benefits Modernization

Social Security and Medicare hold a highly valued position in our society due to the enormous contributions both programs have made to income security for millions of elderly and disabled Americans. Over time, Medicare has played a growing role in protecting retired and disabled individuals from the high costs of health care, in part because health care costs continue to grow at rates considerably in excess of general inflation and in excess of the value of pension and cash benefits.

This widespread public support argues for the Congress to move in a thoughtful fashion to reform the Medicare program, taking the time and steps necessary to achieve significant reforms while also informing and educating the American public.

However, this Committee has received compelling testimony from the Congressional Budget Office and other experts about the demographic and fiscal challenges facing Medicare over the next decade and beyond. I will not repeat those projections and concerns. I will state that to be sustainable over the next fifteen to twenty-five years, the hard work to modernize Medicare must begin now. The Congress, in consultation and partnership with the Administration, should begin this year.

It is highly likely that significant federal investments in Medicare will need to be made as part of the modernization process. In this context, I recommend that the Congress not incur major new benefit expansion costs without also putting into place a framework for broader program reforms that promises to maintain the longer-term financial viability of the Medicare program. The areas I most recommend action in include:

- **Establish a Consumer-Choice Model**—Create a viable consumer-choice health plan model for Medicare that could be fully in effect by the period 2007-2010. Such a model must address the financial access needs of lower-income beneficiaries and the program service requirements of beneficiaries incapacitated by severe mental or physical impairments.
- **Modernize Current Law Benefits**—Modernize the entire range of Part A and Part B benefits, including reconfiguration of beneficiary premium and cost-sharing liabilities, paired with selected benefit improvements, such as improved hospitalization and added drug coverage. In so doing, improve long-term fiscal stability of the Medicare program by building-in design features that promise to improve incentives for efficiency and economy in the utilization of health benefits, without impeding access to medically necessary services.
- **Add Outpatient Drug Benefits**—Add outpatient prescription drug coverage in both the fee-for-service plan and in the Medicare+Choice program.
- **Improve Federal Management of Medicare**—Take steps to ensure that the structures and processes of the Health Care Financing Administration (HCFA) and other entities within the Department of Health and Human Services support effective oversight and management of Medicare. Also ensure that HCFA, in particular, receives the financial resources it needs to properly carry out the responsibilities it has been given.

Section II. Identification of Major Design Shortcomings in Medicare's Current Law Benefits

Modernizing the current law Part A and Part B standard benefit package to address arcane benefit and cost sharing relationships is essential to creating a strong platform for launching new premium and health plan competition concepts over the next decade. Current Medicare benefits are outdated and poorly structured relative to what is typical of health insurance benefits available to most Americans prior to becoming eligible for Medicare. Indeed, certain features are relatively unchanged since they first went into effect in the 1965–1966 period.

Summary of Major Deficiencies in Current Part A and Part B Benefits

The Medicare benefit package has not kept pace with changes and improvements that have occurred in health insurance benefit design in the private sector. Not only does it omit significant benefits, such as outpatient prescription drug coverage, but the premium, deductible and other cost-sharing aspects of the benefit could be designed to better promote appropriate utilization of services, and to bring the Medicare benefit package more closely into alignment with what is customary in other major insurance programs in government and in the private sector. Some payment obligations, such as the inpatient hospital deductible, are viewed as very high relative to what is customary in private health plans, where annual deductibles of \$500 or less applicable to all services are more customary. Alternatively, the Part B deductible has risen to only \$100 from its initial level of \$40 in 1966, although Part B spending has increased many, many times over during the same period.

Medicare has an arcane spell-of-illness concept for inpatient hospital services that can lead to payment of the inpatient hospital deductible multiple times in a given year depending on the timing of repeat hospitalizations. Further, Medicare does not cover catastrophic hospital stays, compared to most private health insurance that covers 365 days of inpatient care, where medically necessary. Coinsurance and co-payment amounts for a variety of other current benefits have not been reassessed and recalibrated in accordance with the latest information on levels and use of services for many years. Also, private health plans typically contain annual limits on total out-of-pocket spending to protect enrollees from excessive costs due to a catastrophic illness. Medicare's current package does not contain such protections.

In addition, private insurance carriers marketing supplemental (i.e., Medigap) policies are permitted to sell policies that permit existing deductibles and cost sharing obligations to be insured against for a premium cost to the beneficiary. While it is widely held that individuals should be free to purchase insurance against risks of any cost they prefer not to incur, this is a practice that the Congressional Budget Office estimates significantly increases costs in the underlying Medicare program and in some instances, may not be cost-effective for beneficiaries.

Major Benefit Improvement Options

To summarize, the following options merit the most consideration:

- **Hospital benefits**—Elimination of inpatient hospital spell-of-illness concept and addition of catastrophic coverage of 365 days of inpatient care.

- **Single deductible**—Creation of a single, shared deductible applicable to spending under both Part A and Part B—this effectively requires a reduction of the inpatient hospital deductible and an increase of the Part B deductible.
- **Cost-sharing**—Reassessment of cost-sharing to require at least a modest level of beneficiary cost-sharing for all benefits, with the possible exception of preventative benefits such as mammograms or colorectal screenings.
- **Out-of-pocket maximum limit**—Creation of a limit on maximum out-of-pocket liabilities for beneficiaries to provide protection against the costs of catastrophic illnesses.
- **Low-income subsidies**—Restructuring of low-income subsidies around reconfigured deductible and cost-sharing obligations to ensure continued financial protection and access to services
- **Medigap adjustment**—Elimination of Medigap coverage of the unified deductible.
- **Addition of outpatient drug coverage**—Please refer to section IV discussion of implications of modernizing the current law package.

Section III. Consideration of an Illustrative Package of Medicare Benefit Changes

In July of last year, the former Chairman of the Senate Finance Committee, Senator Bill Roth, proposed consideration of the following changes to bring Medicare's benefit package more into line with mainstream health insurance coverage (see chart below). Under those recommendations, significant benefit enhancements were paired with increased beneficiary cost sharing in selected areas. The resulting package improved areas where beneficiaries face the highest risk of catastrophic expenses, while expecting beneficiaries to contribute modestly more towards lower-end, more routine expenses. Subsidies for lower-income beneficiaries were restructured to ensure access to all benefits.

To summarize, Parts A and B of Medicare were treated as a unified, comprehensive benefit package without regard to either the underlying sources of revenue or the current voluntary enrollment characteristic of Part B. In the following illustration, the separate Part A inpatient hospital and Part B deductibles were unified in favor of a single deductible that applies to all benefits. A deductible of \$500.00 per year was proposed as generally consistent with private sector health benefits. To minimize out-of-pocket liability adjustments for those beneficiaries that in the short-term are primarily users of Part B services, it might be desirable to phase-up the current Part B deductible, coupled with a phase-down of the inpatient hospital deductible over about a three-year period.

Further, the inpatient hospital spell-of-illness concept, daily hospital coinsurance and lifetime reserve days were all eliminated and replaced by 365 days of inpatient coverage. Note that other combinations of policies are equally possible. However, this is consistent with private sector policies and comports with the earlier policies adopted by the Congress in the 1988 Medicare Catastrophic Benefits Act, which was subsequently repealed. Beneficiary cost sharing on all existing benefits was reevaluated. The lessons from the RAND Health Insurance Experiment of the 1980's taught us that, in general, it is sound benefit design to consider modest cost-sharing on virtually all medical services to promote appropriate utilization and better control program costs, while not impairing medical outcomes. Again, one possible exception is preventative benefits.

Finally, this draft proposal did not include an overall aggregate stop-loss coverage on total beneficiary cost-sharing liabilities on either an annual or lifetime basis. While highly desirable from an insurance protection standpoint, it is potentially very costly to the program, and was foregone in this proposal, in part, because this proposal was paired with a drug benefit that was felt to be a higher overall priority for beneficiaries.

Illustrative A/B Benefits Proposal: Senate Finance Committee; July 2000

Major Benefit Areas	Medicare Plan in 2000	Proposed Plan
Plan Deductible	\$776 Part A deductible (per hospital admission). \$100 Part B deductible (for most Part B services).	\$500 deductible for all Part A and Part B services (separate rules for a drug benefit)
Maximum Out-of-Pocket	None	None

Illustrative A/B Benefits Proposal: Senate Finance Committee; July 2000—Continued

Major Benefit Areas	Medicare Plan in 2000	Proposed Plan
Inpatient Hospitalization	After deductible, \$194 copayment for days 61 to 90; \$388 copayment for days 91 to 150. No coverage for days beyond 150 for regular inpatient hospitalization, and the 60 reserve days may be used only once.	365 days with no coinsurance, after deductible is met
Skilled Nursing	0-20 days = 0 cost-sharing	0 - 10 days = 10% of national average per diem Medicare payment (\$25 for 2000)
(100 day limit on coverage)	21-100 days = \$97 per day for 2000 (1/8 the hospital inpatient deductible).	11-30 days = 20% (\$50) 31-100 days = \$97 for 2000
Home Health Services	0% for home health and 20% for durable medical equipment (DME).	\$5 copayment per visit, with annual maximum of \$100 per beneficiary. 20% for durable medical equipment.
Outpatient Hospitalization and Doctor Visits.	20% after \$100 deductible	20% coinsurance of allowed charge, after deductible is met
Outpatient Mental Health	50% coinsurance after \$100 deductible	50% coinsurance, after deductible is met
Imaging/Clinical Laboratory Services	0% for clinical lab services (also not subject to Part B deductible). Imaging and x-ray—20% after \$100 deductible.	20% coinsurance of claims costing \$50 or more, after deductible is met
Prescription Drugs	Not covered with limited exceptions	See section IV.

Section IV. Considerations in modernizing Medicare Benefits and in the Context of Adding a Drug benefit

Following are some of the key questions and considerations for Members to evaluate:

1) Does treating the Medicare Part A and Part B package as if it were a unified package require changes to the underlying financing structure of the Part A Health Insurance (HI) and Part B Supplementary Health Insurance (SMI) Trust Funds?

The simple answer is not necessarily, unless members choose to undertake larger underlying financing reforms. The benefit reconfigurations can be adopted in each part without changing the underlying sources of revenues (e.g. payroll taxes, premiums and general revenues) that currently apply. What would require legislative and administrative attention is the accounting for Part A and Part B expenses so that they are properly captured and credited to the unified deductible. Similar processes would be needed if the Congress adopted a maximum out-of-pocket limit, whether applied on an annual or lifetime basis. Additionally, and especially if these or similar changes are paired with the offering of a costly new drug benefit, any savings should be captured and channeled into offsetting the cost of the new benefit.

2) What are the major concerns of “stakeholders” likely to be?

The reconfiguration of Part A and Part B benefits potentially affects a variety of stakeholders, including beneficiaries, providers, State Medicaid programs and private insurers offering Medigap coverage. Beneficiaries would face tradeoffs between selected new cost sharing on benefits that have no or minimal cost sharing now, coupled with significant new protections in high-cost areas, such as lengthy or repeated hospitalizations. Selected providers would face new requirements and administrative costs to collect beneficiary cost sharing, with some possible exposure to bad debt. Medigap carriers could be faced with the logistics of offering restructured Medigap plan offerings tailored to the reconfigured Medicare package. In fact, the Congress would need to consider obtaining independent assistance on this latter issue of redesigning Medigap packages, as it has done in the past, from entities such as the National Association of Insurance Commissioners. Finally, States will have a strong interest in the structure of low-income subsidies and their interactions with the Medicaid dually-eligible and other programs designed to assist low-income beneficiaries today.

3) Is there an option for minimizing the effects of changes that Parts A and B benefit modernization would require in the approved Medigap plans, or with respect to other “stakeholders”, including beneficiaries and se-

lected providers? In particular, how might one address some beneficiaries' reluctance to accept changes in Medicare, perhaps even positive changes?

One option to address this question was offered last year in the draft Chairman's mark in the Senate Finance Committee, and I would draw the Committee's attention to it. Simply, the proposal was to bundle all of the benefit modernization reforms, including a drug benefit, into one comprehensive and new benefit offering to Medicare beneficiaries. Last year, this was referred to as the "Expanded Option Plan (EOP)." A key element was that the current law package would remain completely unchanged and continue for the foreseeable future to be available to beneficiaries.

Under that approach, all of the major benefit design reforms (e.g., single A/B deductible, revised coinsurance, new catastrophic hospitalization expansion and outpatient drug coverage) would be "bundled" into the EOP. The EOP would be offered to currently eligible Medicare beneficiaries and to individuals within five years of Medicare eligibility, on a one-time enrollment choice basis. After the 5-year look-back window, all new enrollees into Medicare would be enrolled into the EOP, which over an indefinite number of years would gradually replace the current law package.

Replacement Plan Concept: This approach is analogous to the phase-in model followed by the federal government when it introduced major pension plan reforms to federal employees in the early 1980's, as steps were initiated to gradually replace the Civil Service Retirement System (CSRS) with the Federal Employees Retirement System (FERS). In that model, CSRS-participating employees were given a time-limited opportunity to choose whether to remain in CSRS or to switch to FERS. These were binding elections upon the employee. After a specified effective date, all new federal employees were permitted to only enroll in FERS. Such an approach, adapted to Medicare, has the major advantage of reassuring Medicare beneficiaries that "their Medicare" will remain for them if they choose to retain it.

Such an approach is also conceptually similar to what private employers do in their employee health benefit plans when they offer their employees a "replacement" plan that they intend over time to replace current coverage or benefit designs. Generally, employers are motivated to minimize disruption in their employees existing coverage by offering a new option that better meets the employer's long-term objectives in benefit offerings, and that permits employees to choose between existing coverage and new coverage for some period of time. The rate at which the older plan is phased out and the circumstances for doing so are important political and administrative decisions.

Key Characteristics of the Expanded Option Plan

- Combined (single) deductible for Parts A and B services
- Enhanced inpatient hospital benefits (No separate inpatient deductible; eliminate spell-of-illness concept that can require beneficiaries to pay more than one inpatient deductible if they have more than one hospital admission in a given year; provide 365 days of covered care)
- Modified cost sharing on certain Part B benefits that have minimal or no cost sharing today
- As under current law, selected preventive benefits not subject to the Part B deductible would also be exempt of the combined deductible under the Expanded Option Plan.
- Addition of outpatient prescription drug benefit (see below)
- Separate drug deductible
- Continuous coverage above the drug deductible with increasing federal payments as beneficiaries' prescription drug costs increase.
- The Secretary of the Department of Health and Human Services would be required to conduct a major beneficiary education program and open enrollment season in the year prior to implementation of the Expanded Option Plan to assist beneficiaries in making an informed enrollment selection.
- Medigap would remain unchanged for beneficiaries who elected the current law package. Beneficiaries enrolling in the expanded option plan would not have available to them Medigap coverage for the combined A/B deductible or the drug deductible. Medigap would be permitted to fill-in all other beneficiary cost-sharing obligations.
- Low-income subsidies would be substantially improved.

In closing, it is important to restate that any benefit changes can be adopted directly into the current law structure without pursuing the replacement plan approach. However, there is a growing appreciation that the replacement plan approach may help Members solve certain political and policy issues in a constructive way.

4) Can an outpatient drug benefit be offered as a stand-alone option (such as through a new Medicare Part D option), or could it be fully integrated (now or in the future) into a modernized A/B benefit package?

Medicare spends approximately \$4 billion a year currently on drugs provided to Medicare beneficiaries under very circumscribed circumstances spelled out in the law. However, the most glaring omission in the Medicare benefit package is the lack of an outpatient prescription drug benefit. Medical and health insurance experts have indicated consistently that if the Medicare program were designed today, drug coverage would no more be excluded from the standard benefit package than would any other major component of medical care, such as coverage for hospitalization or physician services.

Under the Parts A and B modernizations discussed above, including the EOP option, a new outpatient drug benefit can be offered either as a stand-alone benefit or integrated into the overall plan. The full integration approach implies a single premium around the entire plan and other changes that could require a significant revamping of the underlying financing structure of Medicare. This may be desirable in the long-term, but it may not be desirable or necessary for Members to address now. As a stand-alone benefit, the drug benefit could have separate premiums, deductibles and cost-sharing obligations tailored specifically to that benefit.

5) Are there any fiscal advantages to pairing the offering of a drug benefit with Parts A and B benefit modernizations?

There is one major consideration, aside from the intrinsic merits of improving current law benefit design. That is, even with significant, catastrophic hospital benefit improvements, which add new costs, the net effect of all the other changes taken together could generate significant long-term savings that could be captured to help underwrite the costs of adding the drug benefit. These savings occur due to a variety of factors.

Under last year's Senate Finance Committee proposal, the EOP options shown in the chart above were paired with a comprehensive outpatient drug benefit. Preliminary Congressional Budget Office scores indicated savings in the range of \$65 billion over ten years could have accrued from the Parts A and B changes, offsetting the cost of a drug benefit that had a gross score of about \$240 billion over 10 years and a net score of about \$170 billion due to those offsetting savings. I must emphasize that all scores are subject to significant re-estimation issues under the latest base-lines and models, but the underlying concept and potential interactions are worth your consideration.

CONCLUSION

Medicare at thirty+years is at a major crossroads. The Congress and the Administration have an historic opportunity to simultaneously begin redirecting the future shape of the program, while also firmly maintaining commitment to the Medicare program's central role in the fabric of the Social Security system. The issues have been widely vetted and consensus is growing around specific directions for change. Any major change to a social program that is as embedded in our society as is Medicare requires significant bipartisan support. In that spirit, I thank you Mr. Chairman for this opportunity to testify, and I stand ready to help you and other Members in any way to advance your work in this important undertaking.

Mr. BILIRAKIS. Thank you very much, Ms. Means.

I know this is a very complicated subject, but you referred to approximately \$70 billion worth of savings over 10 years by combining Parts A and B.

How much of that would result from the change in the deductible, the flat \$500 deductible; or would most of that result from other changes made as a result of combining the two efficiencies?

Ms. MEANS. It actually comes, Mr. Chairman, from three broad concepts. One is partly the change in the deductible. It does generate savings on the Part B side. We would have gone immediately to the \$500 deductible. If you do a phase-in, you will reduce some of the savings from that particular change.

Mr. BILIRAKIS. So if we are talking about a savings in that regard, we are talking about money coming out of the beneficiaries'

pockets, additional money coming out of their pockets for a period of time?

Ms. MEANS. That is correct.

On the other hand, we were also offering that with an expanded hospital benefit and a reduced inpatient hospital deductible.

It is absolutely correct, what I heard a couple of members say earlier, that in any given year more beneficiaries touch the Part B program than touch the Part A program or have an inpatient hospital admission. However, an insurance concept, you don't want to look at just 1 year in isolation; you really want to look over multiple periods of years for providing insurance; and the reduction on the inpatient hospital side is very—the deductible is a very important insurance benefit to beneficiaries.

So it is a tradeoff. You are paying more for more routine, discretionary cost and less for catastrophic illness.

Mr. BILIRAKIS. But over a period of 5 years or 10 years, you are saying that it probably would even out because of the smaller deductible for Part A, or for hospitalization?

Ms. MEANS. Yes.

Mr. BILIRAKIS. However, in marketing the plan to beneficiaries out there I don't know that they would think: "I may go into the hospital 3 years from now or 5 years from now and I would save money, it would cost me less money out of my pocket in that particular year; but in the meantime, it is going to be costing me more."

Ms. MEANS. You had also asked, Mr. Chairman—some of the other sources were, CBO assumed some improvement in utilization ratings across services where we added cost sharing. So it was actually a change in the underlying utilization assumptions.

In addition, we would not have permitted Medigap to fill in the deductible as is the case under current law. That generates—you probably heard separate testimony, I believe from Mr. Crippen, that allowing Medigap to fill in that basic deductible generates fairly significant underlying costs in the underlying benefit package over time.

Mr. BILIRAKIS. Well, thank you.

I don't have that much time left. Depending on how many people we have here, we might be able to do a short second round.

Dr. Scanlon, in your written testimony you express a certain hesitancy, I think, in adopting policies and practices implemented by the private health insurance industry. Now, recognizing Medicare's special status—and we must do that—one of the questions is, how can these private sector practices be adapted for Medicare?

This is actually a bottom-line question for me: How can Medicare use its special status as the largest single purchaser of health care to improve the services it provides to beneficiaries, to enhance the operation of the program and to include prescription drug coverage?

Now, that is going to take some time, so let's just say that I will use an additional 5 minutes and give everybody 10 minutes to inquire.

All right, go ahead, sir.

Mr. SCANLON. Yes, Mr. Chairman. You did perceive our hesitancy in our written statement in this regard, and it is because

Medicare is such a large program. While it provides some advantages in some dimensions, it creates responsibilities in others.

Medicare is the single largest payer of all services; therefore, it is critical to the well-being of individual providers. It is also critical to the system. Medicare is deciding how it is going to cover services; which services it is going to cover, and what it is going to pay for them. This influences the services that are available not just for Medicare beneficiaries, but for other individuals as well.

In that regard, I think what we need to focus on is for Medicare to, in some respects, operate with restraint, to consider some of the processes and procedures that are being employed in the private sector to better manage care, to encourage better use of services, but not necessarily apply them as strongly, because it cannot apply them with the same kind of discretion that is used in the private sector.

In a private sector arrangement, there will often be individual negotiations going on between plans and providers that can lead to sounder relationships that benefit the beneficiaries. Medicare's a national program. It can not engage in those kinds of individual negotiations. It is going to have to establish a set of rules and we are going to have to live with those rules. We have to make those rules ones that are protective of both beneficiaries and providers, and it will mean that we, I think, hold back, so to speak, in terms of some of these provisions.

An example in the testimony that we provided was the global fee that was being used for bypass surgery where a single fee was being paid to hospitals and physicians. This is a form of preferred provider arrangement; it is a rather mild form of a preferred provider arrangement since beneficiaries are free to go to other providers and receive their traditional Medicare benefits. So that's one aspect.

The other thing I think that is important is, though in some ways—I don't know how we accomplish this—we have to overcome our fear of Medicare; and this would relate to the idea of allowing Medicare to inform beneficiaries about the value of services and to remind them about services on an individual basis may actually have some very positive benefits.

You have added in the recent past important services to the Medicare program in the form of screening for cancers. Yet Medicare beneficiaries have made very limited use of those benefits. If there was a more aggressive effort to encourage the use of those benefits, there would be value accruing to both the beneficiaries and to the program.

Right now, those efforts are relatively timid. They may be timid in part because the administrative resources that HCFA has constrains their activities, but they are also timid in part because Medicare identifying individuals and telling them specifically: you have not gotten a mammogram; you have not taken advantage of any of the colon cancer screening services that we cover; that is something that we are not ready for at this point in time.

Mr. BILIRAKIS. You say we are not ready for it?

Mr. SCANLON. We are not ready for it in the sense of being comfortable with the idea of getting a letter from Medicare saying that we have looked at your records and we know that you haven't used

certain services and we encourage you to use them; there could be some very significant concerns raised about that. It is my sense of the possible response by individuals, being "what is the government doing looking at my health care?"

Mr. BILIRAKIS. My question went to prescription drugs also.

You have become quite an expert. I know you have appeared before this committee many, many times. Can we afford to include prescription drugs within the scope of Medicare, basically the way Medicare functions now?

Mr. SCANLON. In terms of the administration of Medicare, looking at the affordability question, I think is a question of the resources that you feel can be devoted to the program. I think earlier, in one of the opening statements—several of the opening statements—the issue was characterized in terms of priorities; and I think that is the critical issue in terms of prescription drug coverage.

Administration of a prescription drug benefit is not a trivial task. We estimated last year that there could be as many as a billion claims a year for prescription drugs, which is more than the total number of fee-for-service claims that are coming in now. Therefore, we really need to focus on building the capacity to be able to process those kinds of claims. It is going to be purchased capacity, just as we purchase the capacity to process claims today through the fiscal intermediaries and the carriers. At issue, I think, is, do we give HCFA resources to purchase that capacity, as well as to see oversee it, effectively? One of the key things we have reported on over the years is the ineffective oversight of contractors and the fact that this puts the program at risk for inappropriate payments, which far outweigh the shortsighted savings we may have gotten on the administrative side. So we need to give HCFA the resources to be able to do oversight effectively.

The second issue for you is the issue of, under what terms are we going to buy that administrative capacity; and options have been discussed of buying simply a third-party administrator to pay these claims versus putting the entity doing this, such as the pharmacy benefit manager at some risk, so that they do the job even better and apply the techniques that they have for more effective management to the program's benefit.

Mr. BILIRAKIS. Well, thank you, Doctor. I know it is a subject you could probably spend an entire day on. In lieu of a second round, I will allow every member to use 10 minutes for inquiring; and the Chair now yields to Mr. Brown.

Mr. BROWN. Thank you, Mr. Chairman. My guess is I won't go the full 10 minutes.

Ms. Moon, I want to ask you about Breaux-Frist 1, as you recall, suggested combining of A and B, and adding a new solvency test to the Medicare program. My understanding is that if in any given year general fund contributions exceeded 40 percent, or were projected to exceed 40 percent outlays, Medicare would be determined to be "programmatically insolvent," I believe. The bill actually prohibits general revenue transfers to exceed that 40 percent of Medicare, Medicare outlays.

Explain to me this solvency test and what, in fact, it would mean for Medicare.

Ms. MOON. I believe—let me start and say, I believe that trust funds were established, particularly the Part A Trust Fund, as with Social Security, to be a protection for beneficiaries; to say, here's a dedicated source of revenue to make sure that there is enough, far enough ahead, that there is not a problem.

From that perspective, then putting—establishing a Trust Fund in which you then put specific limits on the contribution from general revenues, I think is contrary to that notion to a certain degree. It also says that you—the limit will be based upon what is happening to the economy as well as what is happening to health care spending. So it's adding a whole range of additional concerns in terms of thinking about what that trust fund means.

I am sympathetic to the notion that one wants to be prudent in terms of the dollars that are devoted to a program of this sort, but the whole goal of having an entitlement type of program is to allow it to grow as necessary over time, and only then be controlled by the rules that manage the program.

So I find it hard to conceive of exactly what that 40 percent means, because it is going to vary for reasons that don't have anything to do with whether the program is serving its beneficiaries well or meeting other national goals in terms of the Medicare program.

Mr. BROWN. What would have happened if it exceeded 40 percent and Congress had either failed to act or chose not to act? What would happen there?

Ms. MOON. That is an interesting question, and like the statute for Medicare, I think it is a little unclear.

Technically speaking, my understanding is that if there is not enough money in the trust fund to pay benefits, you delay payment for a while. You can only do that for a while; and then it is rather unclear what happens, because you have, really, two conflicting things. You have something that says you can't pay benefits and you have another part of the law that says people are entitled to these benefits. So it really puts kind of Catch-22 on the system in terms of requiring some change or to be a violation of part of the statute.

Mr. BROWN. Okay.

Dr. Scanlon, Dr. Young in his testimony mentioned that combining A and B would allow HCFA to keep track of both inpatient and outpatient services that seniors receive, and he went on to say that, among other benefits, HCFA would be better able to fight fraud under a merged Medicare program because the Office of Inspector General had said, in some cases, Medicare pays twice for the same set of services, once to a Part B provider, once to a Part A provider.

Is that the problem? My understanding is, the real problem is HCFA's information technology systems. Could we deal with the fraud issue equally as well without the merger of A and B?

Mr. SCANLON. Certainly without the merger of the trust funds. In some ways, you can deal with the problem by what I might characterize as a virtual merger of the program through the information systems. The key here is that HCFA needs the capacity to be able to look at services being used by a beneficiary in toto. It actually has some of that capacity already. In the fact that claims

do flow through a common point, coming from both Part A and Part B.

The reality, though, is that the information systems they flow to are not capable of doing the kind of sophisticated screening that would need to be done to make sure that we minimize inappropriate payments.

From our perspective, the administrative side of this issue is that many things can be done keeping a separate Part A and a separate Part B Trust Fund by looking at the program as a whole. And that is critical. HCFA has been doing that to some extent; it needs to be able to do it more.

Mr. BROWN. HCFA's information technology system is, it is a question of funding in large part?

Mr. SCANLON. It is, in part, a question of funding. They have had difficulty in modernizing that system, as you probably are aware. There was a bad experience in the mid-90's with the Medicare transaction system, and then having to turn, when that failed, immediately to the problem of dealing with Y2K and trying to correct all of these old systems.

The final thing that I think has been a significant barrier to modernizing the systems, frankly, has been the BBA and the refinements since the BBA. HCFA has really, in many respects, done an admirable job in terms of implementing the system changes required to implement all of those provisions of the law. But in doing that they have had to modify a set of systems that they know someday are going to be scrapped, but today it is critical they be modified. So payments are made in accord with the new policies that have been enacted in the last 5 years.

Mr. BROWN. Well—and HCFA, as we have discussed here, has over the last—well, when we had the four administrators here, the four previous administrators, and the new one was at the back of the room. And just the budget for HCFA has stayed pretty constant, even somewhat fewer dollars; and I am concerned that while all of them said that the increase for HCFA's budget should be—as HCFA's administrative costs are much less than Medicare+Choice or any other insurance program we know of, that—they all called for at least a 15 percent increase. Some called for 50 percent over a couple of years.

But I am concerned that with this Congress and the President passing a tax cut where benefits went—tax cut dollars went overwhelmingly to the richest people in the country that we are not going to be able to do the things that we need to do to make HCFA run better. To give it the kind of resources that we need and to deal with the fraud issue that Dr. Young talked about and that you talked about, it is clearly going to need some more resources. And while the HCFA administrators have called for more money, I don't know if this Congress will get its act together to be able to do it in light of scarcity of resources again.

So I yield back the balance of my time. Thank you, Mr. Chairman.

Mr. DEAL. Thank you, Mr. Ehrlich.

Mr. EHRLICH. One specific question and one general question.

Dr. Scanlon, I was interested in your comment with regard to the failure to communicate, I guess, with regard to the reforms that

have passed the Congress over the term or, two, regarding new benefits, new services, new therapies and the like. I share your concern with regard to your example that if one of my constituents would receive such a letter, I would certainly hear about it.

What to do? Is a general communications plan better than specificity with regard to individual beneficiaries? How to make people healthier, make the system run better, create a more knowledgeable health care consumer in light of reforms that have passed in recent years?

Mr. SCANLON. Certainly, general education is the first step, and HCFA has engaged in some activities in that regard. Whether they are going to have a payoff in terms of improving over time the use of these services is still not clear. But it is likely to be an insufficient step, and the dilemma is, how do you move from something that's general education to something as specific as I have characterized.

If we could find some trusted intermediary in the context of some agent that could be the source of the specific education, we would be able to potentially bridge the gap between the trust for government and the need for this service.

Mr. EHRLICH. Would physician providers fit the bill?

Mr. SCANLON. Physician providers may fit the bill, but at this point in time, because of freedom of choice and the fact that there isn't a primary physician concept within Medicare, we have no ability to identify which physician we might want to involve in the process of informing beneficiaries about the need for services.

In terms of people, a model that might be expanded but would require a significant amount of thinking to determine how to expand it would be what we try to do on occasion with individuals with chronic illnesses; in other words, to provide them some assistance in the form of someone to do coordination, to inform them about need for services, to inform them about how to access services.

These can be positive in terms of encouraging the right use of services, but we don't have a framework, we don't have a mechanism for that at this point in time.

Mr. EHRLICH. As a cost saving and better health care delivery issue, it is certainly intriguing here.

General question, anybody and everybody; we are just about to complete here, so I only have a few minutes.

I was not here, but I am familiar with the comments the chairman of the full committee, Mr. Tauzin, made with regard to, if he had a magic wand and we were 36 years ago and we were able to begin a new system, literally anew—let me ask the specific question:

If you all had the opportunity to create a new Medicare program, would you combine A and B? Why and why not, which is, I guess, the bottom line question in today's hearing.

So, Doctor, I will start with you.

Mr. SCANLON. There are an incredible number of elements to that question, which are not my province to respond to, that are really your choices. They do involve issues of priority.

There were points that came up in some of the discussion earlier about what should be the financing sources for this program? What

would be the relative importance of each of those financing sources? How would we determine what beneficiaries should pay? What would we do in terms of moving from—if we are starting in 1965, we wouldn't have this issue, but we have it today. What would we do in terms of people that have paid their payroll tax their entire working lives and be saying to them, we now have a unified program, but in order to get it, you have to pay a premium.

These are all choices that you would have to make.

From my perspective, I think it is critical that we would look at this program from a unified perspective in terms of the management kinds of issues they have raised, and this comes back to a choice for you.

We would also want to look at this program from the perspective of, how good is the insurance that it provides? On the Part A side, you have the high deductible and you have very high risk for very sick people at the upper end in terms of hospital stays; and also on the Part B side that if you are very, very sick and you have a very large amount of physicians' bills, there's no limit.

With that, one would say, this is not good insurance and we want to do something better. So we want to take into account what beneficiaries' total liability might be and we want to provide protection against that.

Mr. EHRLICH. Does anyone else want to comment, particularly with regard not just to, clearly, No. 1, policy being quality of delivery of health care services, but also complexity?

Mr. YOUNG. I think, without a doubt, we wouldn't even consider the issue of separate A and B unless the issue of financing was raised, and there is a possibility that one can draw a line between the financing.

But in terms of care delivery coordination, disease management, with what we know today—deductibles, out-of-pocket spending, program administration, fraud and abuse, one single program is a state-of-the-art, not two programs. The private insurance sector 20 years ago, 30 years ago, and even going back to the mid-1900's, as I briefly summarized in my testimony, did have different pieces; and they got rid of that for very good reasons.

But I also agree, you have got some problems you are going to have to deal with on the financing side in how you want to structure and deal with the financing side.

Ms. MOON. I would just like to add that there is a big difference between if we started with the combined program and today, because today what you need to do is spend time on getting all of that, the complexities, right that people have talked about here; and I would rather see the time and effort go into getting some other things right, improving consumer education and information and coordination of data.

You can use, for example, I do in my research use combined A and B data; you have to go through some hoops to do that, but you certainly can link those data. That is not a difficult thing to do; it just takes the resources and the will to do that. And as I mentioned in my testimony, the complexity of the cost sharing certainly needs to be reassessed, but the A-B deductible is not the big part of that. It is the spell-of-illness issue. It is the very high cost on the Part A side, for example, and the lack of stop loss.

Mr. SCHULDER. Hindsight is wonderful, but I was beginning to be active near the Congress on getting the Medicare program passed in 1965, 1962—1961, 1962, 1963, 1964, and you just have to again recognize that we had Wilbur Mills in this building—well, not this building, but next door. We had an enormous amount of politics going into the passage of Medicare and often large amounts of interest being explored, both the physicians' side and the hospital side. So there could have been no way, it seems to me, to project, outside of using a Blue Cross-Blue Shield model that this could work and sharing the costs from premiums and payroll taxes, that came up with something that worked and has worked reasonably well over the last, you know, whatever it is, 40 years; and the framers of the Constitution had to come back and look at it and make changes over the years, over the centuries.

So there is no way to really speculate what you would have done differently in 1965, if you had a chance to redo it, except to say that we have to keep saying again, the purpose is to make sure that good health services, using the best technology, the best findings of pharmacology, of the health profession, the medical profession, gets to the users in an efficient and affordable way quickly; and I can't quite describe what that would look like, but that is the goal.

Mr. EHRlich. Thank you.

Mr. DEAL. Mr. Green.

Mr. GREEN. Thank you, Mr. Chairman. I apologize for being in and out, but we have an E-911 hearing upstairs and that is also part of the importance of what is going on here in Congress. But I appreciate that our panel—and as I didn't listen to your testimony, but as I read the testimony, I notice that each of you has different goals for the Medicare program.

For example, Ms. Moon, your goals for the Medicare program were simply simplifying the program, improving cost sharing and making it more rational for beneficiaries, achieving greater efficiency in the management of the program and treating the Medicare program as a whole in considering the financial issues.

Mr. Scholder, you state that we should enhance expanded quality of the service to beneficiaries and strengthen the overall program.

Ms. Means, your statement reflects vastly different goals which are to establish a consumer choice model, modernize current benefits, add outpatient drug benefits and improve Federal management of Medicare.

And, Dr. Young, your statement reflects the desire to make the program more reflective of the private sector model and to include disease management programs, improve program administration, eliminate the program's structural problems and other substantial reforms.

These are all—some of the common goals in your testimony, that for example, we need greater disease management, coordination of the care and improved customer service. Are there ways to achieve the more immediate success in these areas on which we agree without introducing some of the more complicated factors such as changes in deductibles, program financing or benefits, and still achieve what all of you seem to have in common?

Ms. MOON. I think one first step you could take, if you don't want to talk about additional resources is—or only modest additional resources is devoting the time to providing a better set of goals and some modest increase in resources to improve the kinds of coordination of care and beneficiary education that we are talking about. Those are very important to having the program work well.

They don't achieve some of the desires to expand or improve benefits, which I think are also there, but at the very least it seems to me that the dollars that would be necessary to improve this program substantially and keep it at a reasonable level of expenditures, while being cognizant of fraud and by finding ways to better coordinate and sometimes achieve savings, would be certainly worth some initial investment.

Mr. GREEN. We can again do that without fighting the battle of the changing deductibles or how we finance it in the benefits. Can we do some of the commonality that would benefit the providers, but also the beneficiaries?

Dr. Young.

Mr. YOUNG. There are a lot of things that can be done that are unrelated to the A/B division and split, of course. I would, though, encourage you to seriously consider adding to that list the deductible issue, because it does have a lot of very perverse incentives as I talked about in terms of quality of care and site of care. And I think Mr. Scanlon referred to it as the virtual A/B merger. As I said earlier, you might want to separate the issue of financing, but there is an awful lot in the system that could benefit by a virtual or real combination and elimination of some of the incentives that can be very perverse to high-quality care.

Ms. MEANS. Congressman, I would echo that. I think even without adding resources in a budget-neutral fashion. You can restructure some of the A/B benefits in a way that would result in an overall better package for beneficiaries from an insurance protection standpoint and also gain some savings and use it to offset some of the improvements that you would make even within the A/B benefit structure. And I would just emphasize what I said earlier in my testimony, that these kinds of changes are possible without in any way entering into changing the underlying financing structure of the trust funds today.

Mr. GREEN. Mr. Schulder.

Mr. SCHULDER. On the questions of combined deductible, I just want to make it clear to this committee that to increase the deductibles for Part B services to \$500, \$400 is to put a dollar bar to access the services for average and lower-income seniors, and we will oppose that. The \$100 deductible is doable, it is rational, but to increase that to a substantial level such as 4- or \$500 we think is going to prevent services. People don't for the most part shoot their way into the doctor's office or into hospital beds. They are there because they need the service.

Mr. GREEN. Obviously I agree, and because I have seniors who say, I have to come up with \$792 before I can go to the hospital, even if they need it.

Mr. Schulder, some people believe that Congress should not add a universal prescription drug benefit before substantially reforming

the entire Medicare program. It seems there is a lot of disagreement about reforming Medicare, but a near universal agreement on finding some type of drug benefit. What is your view and Alliance's view on that matter?

Mr. SCHULDER. I don't think beneficiaries or the Nation as a whole can wait until we solve all the structural problems. We need this benefit now. We need it as a part of the Medicare system, a defined benefit, a universal benefit, a voluntary benefit, and a benefit that is going to use the pharmacological findings rapidly so that people can find relief for their ills and their needs. We need it now, and we don't need it as part of an overall Medicare so-called reform program. We need it first and foremost, and we would hope to see this Congress this session do it.

Mr. GREEN. I don't think I could say it better. I yield back my time, Mr. Chairman.

Mr. DEAL. Thank you.

I want to follow up on a question Mr. Ehrlich asked you perhaps to make it a little easier, without perhaps going into great discourse about it. Putting aside the decisions that were made in 1965, putting aside the issue of trust fund and the financing mechanisms that differentiate between the two programs, A and B, and assuming that you are a panel assembled by Congress as advisors for Congress's consideration of a Medicare program, as a matter of first impression, would any of you advise that we bifurcate into the two sections A and B if we were for the first time adopting such a program?

Mr. YOUNG. No.

Ms. MEANS. No.

Mr. DEAL. Anyone?

I believe I see universal agreement that you would not endorse such a concept. That being the case, then, let's, in the nature of reform which we are considering today, consider those things that happened some 35 years ago or so and see why they should be an impediment to us reaching this decision now. The first one, I suppose, is a philosophical question, and I think it is one that we haven't maybe as a Nation come to grips with. So I would put it to each of you.

Philosophically is it the primary responsibility to pay for health care—should that responsibility rest on the individual or their generation, or should that be a primary responsibility of the generation that follows them?

I don't see any takers.

Mr. SCHULDER. Yes, it is the responsibility of society. If this society decides that the provision of health care services is a primary citizenship right and a responsibility of the government for the good of the whole community, it is a responsibility carried from generation to generation, from generation to generation—the microphone is gone—and now it is back.

Mr. DEAL. You have to give the right answer for it to work.

Mr. SCHULDER. It is pay as you go. You are suggesting maybe this generation pays for it or the next generation. My parents use Medicare, my children will use Medicare, I will be using Medicare as soon as I leave employment. It is a societal responsibility, it seems to me. It is not a simple generations thing.

Mr. DEAL. So it is a shared responsibility.

Mr. SCHULDER. It is shared. It depends on how we want to use our resources. Do we want to include health care as one of basic citizenship rights and responsibilities of government? At least that is the way I look at it. You can cut it any way you want. Once you create the system in terms of private market involvement or all the rest, but it is the decision of this society do we want to make health care services for older people, disabled persons or everyone a basic part of citizenship rights.

Mr. DEAL. Dissecting the question a little bit further, and you may elaborate on this, which of the funding mechanisms that we currently have A or B in your opinion most appropriately represents where that responsibility for paying for health care costs should be placed? Is it under the A formula, or is it under the B formula?

Ms. MOON. I believe that the combination that we have of payroll taxes, of individuals' premium contributions, and of general revenues is a reasonable combination. The question is what is exactly the right balance, and that is much more difficult to answer.

But general revenues have the advantage that they ask people of all ages to pay on the basis of ability to pay so that high-income seniors, for example, contribute to the Medicare program.

Payroll taxes are desirable from the standpoint of many beneficiaries and individuals because they have relatively painless tax that comes out of your payroll. Americans like it much better than economists like myself do. But they see it as a fair system to have a basic small amount come out of their payroll to provide for the future, and I believe that having beneficiaries pay a contribution is also important to make them understand and appreciate the program.

So I believe that whether it is by accident or design, the notion of having all three of these sources of revenues has been a very good idea. The question to go forward into the future is what is the fairest way to do the combination that is going to be necessary to fund this program?

Mr. DEAL. So, in other words, if we are going to reform, then we do not necessarily need to look at a different approach to funding. It is the very question of where the additional cost—and I think everybody agrees there are going to be additional costs, especially if we add a pharmaceutical benefit. The question is from which of those sources, those combination of sources, do we ask this extra burden to come from. Would everybody generally agree with that proposition?

All right. Mr. Schulder and Ms. Moon, at least in your written testimony both of you allude to the fact that we may need to revisit the payroll tax portion of the funding formula. Have either of your organizations taken a firm position on that issue?

Mr. SCHULDER. Speaking for the Alliance, no, we do not have a firm position on that. We are a new organization, and we were building a catalog of policy positions. We haven't looked at that quite yet. But it would seem to us and to me that all of us face increased out-of-pocket costs to pay for our health care. Employees are paying higher premiums.

It is not unreasonable to think that the payroll tax can be looked at any point in time to see whether or not it is providing a fair share, if that is the right word, to the overall costs of the program. The trustees tell us we are about 1.97 percent of payroll that we need to add to the system so it is in balance for 75 years. That is about \$300 a year and 1 percent for the workers' side. One percent for \$30,000-a-year worker would amount to approximate \$300 a year in additional taxes, as well as for the employer the same amount. That would bring the program into solvency for the full 75 years.

I am not sure that 75 years means anything to any of us given the nature of life and changes in medicine, but some small increase in the payroll tax, it seems to me, should be considered. Nobody likes to talk about it, but it is part of the basic financing, and American workers with their productivity can afford to have people take a look at that and consider an increase in the payroll tax.

Ms. MOON. I don't represent an organization. The Urban Institute doesn't take positions on these things, so I represent me. I am a baby boomer, and I am very cognizant of the fact that baby boomers are going to be a drain on the system. I think, then, that considering changes in financing that ask me as a baby boomer to contribute over time are a good idea. The only way we now have to try to establish a way to have me pay for some of my benefits in the future is through a higher payroll tax contribution that would go into the trust fund. General revenues can be asked of me when I get to be 65 and 66 and I am on the program and to help contribute as well.

So I think both of those have a role, but I think the payroll tax because it is a dedicated tax, goes into a trust fund, and it is supposed to be there to smooth out some of these things, and it should be looked at that way.

Mr. DEAL. That is consistent with your testimony that you believe that combining the programs may pose some jeopardy to the trust fund portion of the surplus that has accumulated in that trust fund over a period of years.

Let me shift to another issue, Ms. Means, and I will ask you the question, so if you want to respond to that one, you may do so at the same time. One of concerns raised by Ms. Moon is the issue of combining the programs having an undue burden by raising the deductible issue. Would you address that, please, and also the other previous question if you would like?

Ms. MEANS. When we were looking at this issue last year on the Senate Finance Committee, the issue of raising the deductible on the Part B side, clearly that is something that members have a great deal of concern about, addressing their constituents' issues about that.

I think, first of all, the Part B deductible has stayed way, way out of whack relative to the increase in spending. I think most of the members understand very clearly the extent to which it has not kept pace with its original design and purpose, which was to rise over time in a way much more in step with the increase in spending, as the inpatient hospital deductible has done on the Part A

side. So there is a huge disparity in relative responsibility for those deductibles toward affecting the total cost of the program.

When we were looking at this issue last year, we thought it was very important to deal with the concerns of low-income beneficiaries. So in the context of proposing to raise the Part B deductible, we also proposed considerably more generous subsidies than exist today under current law for low-income beneficiaries. We raised the subsidies up to 150 percent of poverty, and they were fully federally financed up to a certain level. So we did not put that burden on States. Even with that increased cost, you can still gain some overall savings because effectively more middle- and upper-income beneficiaries are contributing more to the Part B benefit through the deductible.

Mr. DEAL. So you can achieve a favorable result.

Ms. MEANS. Yes. And as I mentioned earlier, you are getting improved insurance on the changes in Part A, and that should be looked at not just in 1-year pieces, but over the life of the benefit.

Mr. DEAL. Thank you, Mr. Schulder.

Mr. SCHULDER. There are some people who would suggest that the payroll taxes are relatively regressive, and there is some truth to that.

Mr. DEAL. I believe the average individual pays more in payroll tax than they do in income tax. So to raise it, as you had previously indicated might be a suggestion, would be very politically difficult.

Mr. SCHULDER. I realize that, but overall we want progressive financing for this program. I would think that a significantly high deductible for all services of, say, 500 is a very, very regressive sickness tax, if you will, and we will oppose that. We do not think that, again, raising the financial bar to seeking services is the way to assure a healthy population of any age.

Mr. DEAL. Dr. Young, I am going to get you to comment maybe on this sort of as a part of an answer, but you have alluded to the fact that the merger of the two programs would be consistent with the evolution that has occurred in the private insurance industry, and you have made reference to that, and one of the things you have said is that it would allow service to be rendered at the most appropriate point of service. Would you expand on that a little bit, and also this issue of the deductible as to whether or not that could be accommodated to solve the problems that Mr. Schulder and Ms. Moon have alluded to?

Mr. YOUNG. From the time the Medicare program was enacted in 1965 to the present, where care is furnished has changed dramatically. Today care can be furnished in multiple sites, some of which are Part A and Part B. I mentioned a surgical procedure that could be a Part A hospital or an ambulatory Part B service. Some acute care can be in a nursing home. It can be in a hospital.

The kind of services, where they are provided, and who provides them has changed. So the Medicare structure and particularly the out-of-pocket costs can penalize somebody from the appropriate side of care or the side of care that happens to be local to where they live based on their structuring. In the private sector having the single deductible allows you to deal with that, and having the contracting flexibility to negotiate fee schedules for different pack-

ages of services that the Medicare program does not have except under waiver or special authority gives you a lot of flexibility to put together the bundle of care that an individual really needs, by the provider they need, without being constrained by Medicare's payment policies based on the type of facility or out-of-pocket spending or deductible policies.

Mr. DEAL. Well, I want to thank all of you. I believe we have exhausted the members, if not their questions. We, too, thank all of you. This has been a very good panel. We appreciate your time in coming and being with us today, and we invite you to come back again. Thank you very much.

[Whereupon, at 12:47 p.m., the subcommittee was adjourned.]
[Additional material submitted for the record follows:]

UNITED STATES GENERAL ACCOUNTING OFFICE
WASHINGTON, DC 20548
August 7, 2001

The Honorable MICHAEL BILIRAKIS
Chairman, Subcommittee on Health
Committee on Energy and Commerce
House of Representatives

Subject: *Medicare Reform: Post-Hearing Questions Related to Modernizing Medicare and Merging Parts A and B*

DEAR MR. CHAIRMAN: On June 14, 2001, I testified before the Subcommittee on issues related to modernizing the Medicare program.¹ Specifically, I discussed how reforms based on a more unified view of the program might affect (1) program financing and assessments of the program's financial health, (2) cost-sharing requirements, and (3) program management, including administration and promotion of quality care.

This letter responds to your July 17, 2001, request that GAO provide answers to questions related to the June 14 testimony. Your questions, along with our responses, follow.

Question 1. How would you design a protection for low-income beneficiaries so that the cost of a combined deductible set higher than the current Part B deductible does not become a barrier to needed services?

Some have suggested establishing a single deductible to replace Medicare's current \$792 deductible for part A hospitalizations and the annual \$100 deductible for part B services. A combined deductible, lower than the current part A deductible but higher than the current part B deductible, could reduce financial barriers for beneficiaries who need to be hospitalized. However, many beneficiaries who use Medicare services are not hospitalized and would thus be responsible for higher out-of-pocket costs.

Whether a combined deductible would prevent some beneficiaries from obtaining necessary care would depend upon the details of the proposed deductible change as well as other beneficiary cost-sharing reforms that might be adopted. Discussions about specific actions designed to protect beneficiaries and avoid the creation of financial barriers should consider this larger context.

One way to help beneficiaries overcome financial barriers to care may be to better promote existing programs, such as Medicaid, that assist qualified beneficiaries with health care costs. Many eligible individuals do not participate in these programs, in part because some are unaware that these programs exist and the requirements for demonstrating eligibility are complex.² The Congress could also consider whether to adjust the current eligibility thresholds for Qualified Medicare Beneficiaries for whom Medicaid pays Medicare cost-sharing obligation. Alternatively, the Congress could consider other targeted options, such as establishing an income-related sliding scale for the deductible, if existing programs did not adequately address any negative implications resulting from a combined deductible.

Question 2. In your testimony, you state that Medicare's current cost-sharing requirements are not well-structured to promote prudent use of discretionary services.

¹ *Medicare Reform: Modernization Requires Comprehensive Program View* (GAO-01-862T, June 14, 2001).

² See *Low-Income Medicare Beneficiaries: Further Outreach and Administrative Simplification Could Increase Enrollment* (GAO/HEHS-99-61, April 9, 1999).

How can a merger of Parts A and B improve Medicare's cost-sharing requirements and serve as a tool to curb excessive utilization of services?

Private insurers generally establish cost-sharing arrangements that require coinsurance or copayments for services that may be discretionary and could potentially be overused, to encourage beneficiaries to consider their need for services and steer patients to lower cost or better treatment options. Medicare's current cost-sharing structure fails to promote prudent use of services and to protect beneficiaries from high out-of-pocket costs. Consequently, proposals have been introduced to reform Medicare's cost-sharing requirements.

Rethinking the relationship between parts A and B could facilitate the development of better cost-sharing requirements. It may be easier to revise Medicare's cost-sharing requirements if these changes are made in conjunction with other revisions to the part A and B structure. However, cost sharing could be revised under Medicare's current structure without merging parts A and B. For example, the Congress recently eliminated cost-sharing requirements for various cancer screening tests and vaccinations to help ensure that affordability is not a barrier to these important services.

Question 3. You mentioned in your written testimony that incorporating cost-sharing changes into Medicare's information systems would take time and resources. Do you have an estimate as to the time and resources needed to make these system changes?

The adoption of cost-sharing reforms, such as implementing a single deductible or an out-of-pocket spending cap, would require significant improvements in the Centers' for Medicare and Medicaid Services (CMS) ability to track service use by beneficiary. CMS is limited in that capacity today, not because Medicare is split into parts A and B, but because of deficiencies in the agency's information systems. Currently, Medicare's systems focus on processing and paying claims submitted by providers. As one step in that processing, both part A and part B claims are sent to a single program, the Common Working File, where spending by an individual beneficiary can be tracked. However, this software program, like some other software CMS uses, does not always perform adequately and is difficult to modify or improve because it is so antiquated. Many changes have been made to CMS' systems in recent years because of the Balanced Budget Act and subsequent legislated revisions. Similar shorter-term fixes might be made to track beneficiary cost sharing. We do not have an estimate of the resources or time that would be needed. However, it would be critical that enough resources and time be devoted to ensure the changes perform correctly from the outset to avoid confusing and troubling significant numbers of beneficiaries.

Question 4. In your written testimony, you mentioned a phase-in to a unified program. How would you design such a phase-in? How would it soften some of the impact of a merged program?

Approximately 2 million individuals (5 percent of beneficiaries) are eligible for Medicare but do not participate in the voluntary part B program and pay its separate monthly premium (\$50 for 2001). A much smaller number, 400,000, are enrolled only in part B but not part A. Those enrolled in only one part of the program often have private insurance from a previous employer or other source to make up the difference. If Medicare parts A and B are combined and beneficiaries are required to participate fully in the unified program, beneficiaries who are now enrolled in only one part of the program would have to pay additional premiums for coverage they may already have from another source. Requiring full participation in a unified program would also increase costs to the government for care that is now covered privately.

If Medicare is unified, providing for a phase-in period is one approach that might reduce any unintended negative effects resulting from the reform. The Congress could, for example, require new beneficiaries to participate in the unified program while allowing existing beneficiaries the option of remaining in the current program with its separate part A and part B structure. Other approaches could also be explored. For example, reform provisions might include all beneficiaries in a unified Medicare program but allow those individuals who choose not to participate fully to receive partial benefits.

Question 5. In your written testimony, you discussed various pilot projects that CMS has conducted to break down the barriers between Medicare's Part A and Part B. What lessons can be learned from these demonstration projects that can be applied to improve the care provided to all Medicare beneficiaries?

Private insurers employ management techniques designed to improve the quality and efficiency of services purchased, such as targeted beneficiary education, preferred provider networks, and coordination of services. The National Academy of Social Insurance (NASI) reviewed such private sector practices. NASI concluded that

private sector practices could potentially improve Medicare but would need to be tested to determine how well they could be adapted to reflect the uniqueness of Medicare both as a public program and as the single largest purchaser of health care.

Medicare has experimented with innovations that bridge part A and part B services. For example, it tested the impact of making single "global" payments to selected hospitals for all services both hospital and physician related to coronary artery bypass surgery. Based on the results of this and other experiments, such innovative approaches may have the potential to cut program costs, save money for beneficiaries, improve health outcomes, and increase beneficiary satisfaction with the quality of care.

However, wide-scale implementation of some innovations may be difficult in a large, public program such as Medicare. Private insurers typically have wide latitude in how they run their business. The adoption of some private sector approaches may require new statutory authority for CMS. For example, CMS' ability to encourage the use of preferred providers is limited, in part because the Medicare statute generally allows any qualified provider to participate in the program. However, it is important that CMS continue to test private sector innovations to determine their effects and whether they can be adapted to Medicare. The Congress can then decide, based on the test results, whether Medicare should permanently adopt the innovations.

Question 6. One of the key shortcomings of the Medicare program is its lack of an overall cap on out-of-pocket costs for beneficiaries. If such a cap were put in place, how could the additional costs to the program be balanced? How would a merged program help facilitate Medicare's adoption of a catastrophic cap?

The average beneficiary who obtained services in 1997 had a total liability for Medicare-covered services of \$1,451, consisting of \$925 in Medicare copayments and deductibles in addition to the \$526 in annual part B premiums. Total Medicare cost sharing can be much higher for beneficiaries with extensive health care needs. For example, in 1997 approximately 750,000 beneficiaries (2.5 percent) were liable for more than \$5,000.

Some have suggested imposing a cap on beneficiary out-of-pocket costs to protect those who require extensive health care services. The additional cost of providing this catastrophic coverage could be offset by raising the part B deductible or creating a combined deductible for part A and part B services. This would increase out-of-pocket costs for a share of beneficiaries. However, in return, they would receive additional insurance in the form of protection from catastrophic costs. If such an approach were adopted, it would be important consider how the entire package of cost-sharing reforms might affect beneficiaries' out-of-pocket expenses.

Capping beneficiaries' out-of-pocket expenses may be more easily accomplished in conjunction with other program reforms that could include the creation of a more unified program. However, such protection could be added within the current program structure. In either case, the Congress would need to decide on how to allocate the cost of such coverage among beneficiaries and taxpayers.

Question 7. It has been argued that many of the benefits to be achieved through consolidating Parts A and B of the Medicare program could be achieved through administrative action. It's obvious that administrative action hasn't been taken in many years. Why is that the case? Is there something inherently difficult in implementing such changes by administrative fiat? How would you suggest that we facilitate the timely implementation of these improvements?

Rethinking the relationship between parts A and B has many potential benefits. Some of the changes discussed to modernize Medicare, such as restructuring cost sharing, instituting a single deductible, and adding a cap on beneficiaries' out-of-pocket costs do require statutory changes. However, adopting a more global perspective regarding parts A and B in administering and assessing the program can have benefits. Currently, the financial health of Medicare is largely judged by the solvency of the part A trust fund. A more comprehensive view of the program can lead to a better understanding of the financial challenges Medicare faces. It is not essential that policymakers combine the trust funds or take legislative action to obtain this perspective. In fact, the Medicare Trustees currently report one comprehensive indicator of the program's financial status: estimated total Medicare spending as a percentage of the Gross Domestic Product. What is important is that both the public and policy makers recognize that more comprehensive measures can better inform the debate over necessary Medicare reforms.

Accomplishing more administratively is handicapped by not being able to view the entire program's impact on beneficiaries and providers on a more timely basis. Our previous work shows that the Health Care Financing Administration (HCFA) operated Medicare with outdated information technology systems unsuited to meet re-

quests for basic management information within reasonable time periods. For example, the agency could not readily track payment and service-use data at the beneficiary level. It will be important for the Congress to ensure that CMS has the capacity to carry out its mission in the 21st century. Such capacity is critical to implement desired reforms, make administrative changes, or inform Congressional debate when course corrections seem necessary.

If you or your staff have any questions regarding this letter, please contact me or Laura Dummit at (202) 512-7114.

Sincerely yours,

WILLIAM J. SCANLON
Director, Health Care Issues

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